Mississippi EMS

The Law, Rules and Regulations

Division of EMS
Mississippi State Department of Health
P.O. Box 1700
Jackson, Mississippi 39215-1700

Equal Opportunity in Employment/Service

*Revision July 2003
As Approved for Intent to Adopt to State Board of Health
January 14, 2004

Section 6

EMS Driver

EMS Driver
Section 6

The Law §41-59-5.

6.1 Training Authority EMS-Driver

These guidelines and minimum standards are set forth in order to establish a minimum level of training for the EMS Driver in the state of Mississippi. These guidelines and minimum standards shall be met by all EMS Driver courses in the state. Additionally, organized EMS districts as recognized by the DEMS, are authorized to provide this training. The DEMS may approve EMS Driver programs if it is determined after review by the DEMS staff and the Medical Direction, Training and Quality Assurance Committee that the objectives of the training program equal or exceed those of the state of Mississippi. All EMS Driver training programs must have the DEMS approval prior to the start of class.

6.2 EMS Driver Curriculum

EMS Driver Curriculum must conform, at minimum, to the National Standard Emergency Vehicle Operator Curriculum developed by the United States Department of Transportation and all current revisions as approved for use by the DEMS. Minimum hours required for EMS Driver are: 4 didactic, and lab instruction sufficient to ensure operator competency, minimum 4 hours. Written permission from the DEMS must be obtained prior to the start of an EMS Driver course.

6.3 Request for Approval of EMS Driver training programs

Note: A list of DEMS approved EMS Driver training programs will be available at the DEMS office and DEMS web site.

6.3.1. Request for approval of EMS Driver training programs not contained on the approved list shall be sent to DEMS with evidence and verification that:

a.) the EMS Driver training program meets, at minimum, the requirements of the EMS Driver curriculum as given in this section.

b.) there are EMS Driver Instructor certification and re-certification requirements, including an evaluation of instructor terminal competencies, provided in the requested training program.

Note: Credentialed EMS Instructors of DEMS as trained through the MS EMS Instructor Training Program, and in good standing, are considered as meeting the above requirement.

6.3.2. Approval of any EMS Driver training program curriculum must be given by the Medical Direction, Training and Quality Assurance Committee (MDTQA) and the DEMS, prior to the start of any classes.

6.4 EMS Driving Training Programs

6.4.1. The length of the EMS Driver course shall not be less than eight (8) hours (didactic and practical).

6.4.2. The complete EMS Driver educational program shall be designed to provide the knowledge that will allow the student to safely operate emergency vehicles.

6.4.3. The program shall consist of, at minimum, two components: didactic instruction and practical evaluation. The time required to complete each component may vary, in part being dependent on the ability of students to demonstrate their mastery of the educational objectives by written, verbal, and practical examination.

6.4.4. The program shall maintain on file, for each component of the curriculum, a reasonable comprehensive list of the terminal performance objectives to be achieved by the student. These objectives shall delineate mastery in all competencies identified, including curriculum documentation, measurement techniques used, and the records maintained on each student's work.

6.4.5 The student shall be informed about the methods and data used in determining grades and about the mechanism for appeal. Conditions governing dismissal from the program should be clearly defined in writing and distributed to the student at the beginning of the training program.

6.4.6 Evidence of student competence in achieving the educational objectives of the program shall be kept on file. Documentation must be in the form of both written and practical examinations.

6.4.7. Classroom and field practical faculty must prepare written evaluations on each student. Documentation should be maintained identifying the counseling given to individual students regarding their performance and the recommendations given to students must be maintained. Instruction must be supported by performance assessments.

6.4.8. Faculty must be presented with the program's educational objectives for uses in preparation of lectures and field practicals. The course coordinator must ensure that stated educational objectives are covered and should answer any questions from students or clarify information presented by a lecturer. The field practical is a period of supervised experience.

Policy for Administration

Operational Policies

1. Student matriculation practices and student and faculty recruitment should be non-discriminatory with respect to race, color, creed, sex or national origin. Student matriculation and student and faculty recruitment practices are to be consistent with all laws regarding non-discrimination. It is recommended that records be kept for a reasonable period of time on the number of students who apply and the number who successfully complete training.

6.5 EMS Driver classes, class approved

6.5.1. The DEMS may approve EMS Driver training classes if it is determined, after review of EMS Driver class request forms, that the objectives of the class equal or exceed those of the State of Mississippi.

Note: EMS Driver class approval forms can be requested from the DEMS or be completed on the DEMS website.

6.5.2. Credentialed EMS Driver instructors must complete the class approval form and submit to the DEMS, at minimum, fourteen calendar days prior to the first day of class. The DEMS will assign a class number to all approved requests and return to the credentialed EMS Driver instructor. Incomplete paperwork will be returned without action.

6.6 EMS Driver classes, final roster

6.6.1. Final rosters shall be completed by the credentialed EMS Driver instructor immediately following the end of training. The final roster shall be inclusive of all students successfully completing the course. The final roster will note students who withdrew, failed, and completed the EMS Driver class.

Note: The final roster form can be obtained from the DEMS or be completed on the DEMS web site.

6.6.2. Students successfully completing an EMS Driver course will not be eligible for state certification until a final roster is on file with the DEMS.

6.7 EMS Driver Training Programs, minimum admittance criteria

6.7.1. Possession of a valid driver's license
6.7.2. Age of at least 18 years.

6.8 EMS Driver Refresher Training

EMS Drivers are required to complete an initial EMS Driver course. There is currently no DEMS approved refresher training course for EMS Driver re-certification with the exception of DEMS approved vehicle operation monitoring system(see note below).

Note: Licensed ambulance services operating approved vehicle operation monitoring systems are required to repeat the didactic section of their training program and submit a copy of the latest employer approved performance driver monitor strip/record.

6.9. Prerequisites to certification as an EMS Driver (training obtained in Mississippi).

6.9.1 Age of at least 18 years.
6.9.2. Completion of the Board's approved EMS Driver Training Program.
6.9.3. Possession of valid driver's license.

6.10. Prerequisites to certification as an EMS Driver (training obtained in another state).

6.10.1 Age of at least 18 years.
6.10.2. Completion of the Board's approved EMS Driver Training Program.

6.10.3. Possession of valid driver's license.

6.10.4. Written verification that training obtained out of state meets the guidelines of the Mississippi EMS Driver Training Program(s).

6.10.5. Verification of training within the past two years, or written verification of training from sending state and of current status.

6.10.6. Submission of official driver's license history concurrent with date of application.

Note: The DEMS maintains the right to refuse reciprocity to any EMS Driver if the submitted curriculum does not meet the requirements of this section.

6.11 Temporary EMS Driver Certification.

6.11.1. The DEMS may issue temporary EMS driver certification not to exceed 90 days. Temporary certification will be issued only upon receipt of a written request from an owner/manager of a licensed ambulance provider. Licensed ambulance providers may utilize personnel awaiting temporary EMS driver certification provided that such providers notify the DEMS prior to employment.

6.11.2. A temporary EMS Driver certification will not be granted to an individual who has previously been issued a Mississippi DEMS EMS Driver certification.

6.12. EMS Driver Certification

6.12.1. Any person desiring certification as an EMS Driver shall apply to the DEMS using forms provided (application for state certification). All certification applications must be accompanied by a twenty dollar ($20.00) money order payable to the Mississippi State Department of Health. Also include a copy of EMS Driver course certificate of completion, a copy of a current state drivers license and complete a successful review by the DEMS of the driver's license history from the Mississippi Highway Patrol.

6.12.2. An EMS Driver certificate shall be valid for a period not exceeding four years from the date of issuance and may be renewed provided that the holder meets qualifications as required by the Board. The expiration date of each EMS Driver certificates shall be the same as the holder's driver's license.

6.13. EMS Driver Re-certification

Any person desiring re-certification as an EMS Driver shall apply to the DEMS using forms provided (Application for state certification). All re-certification applications must be accompanied by a twenty dollar ($20.00) money order payable to the Mississippi State Department of Health. Also include a copy of EMS Driver course certificate of completion and a copy of current state driver's license. The DEMS will conduct a review of the applicant's driver license history from the Mississippi Highway Patrol.

6.14. EMS Driver, Grounds for Suspension or Revocation.

6.14.1. Fraud or any mis-statement of fact in the procurement of any certification or in any other statement of representation to the DEMS or its representatives.

6.14.2. Gross negligence.
6.14.3. Repeated negligent acts.
6.14.4. Incompetence.
6.14.5. Disregarding the speed regulations prescribed by law while on duty.
6.14.6. Revocation or any other loss of Mississippi driver's license.
6.14.7. Failure to carry the DEMS issued certification card while on duty or failure to wear appropriate identification as approved by DEMS.
6.14.8. Failure to maintain all current EMS Driver training standards as required by the DEMS.
6.14.9. The commission of any fraudulent, dishonest, or corrupt act which is substantially related to the qualifications, functions, and duties of pre-hospital personnel.
6.14.10. Conviction of any crime which is substantially related to the qualification, functions, and duties of pre-hospital personnel, or the conviction of any felony. The record of conviction or a certified copy thereof will be conclusive evidence of such conviction.
6.14.11. Violating or attempting to violate directly or indirectly or assisting in or abetting the violation of, or conspiring to violate, any provision of this part of the regulations promulgated by the DEMS, pertaining to pre-hospital personnel.
6.14.12. Violating or attempting to violate any federal or state statute or regulation which regulates narcotics, dangerous drugs, or controlled substances.
6.14.13. Addiction to, excessive use of, or misuse of, alcoholic beverages, narcotics, dangerous drugs, or controlled substances.
6.14.14 Suspension or revocation of any DEMS issued certification may effect other DEMS issued certifications at all levels.

Section 7

EMT-Basic Life Support

EMT-Basic Life Support

Section 7

The Law §41-59-5. §41-59-33. §41-59-35. §41-59-37. §41-60-13.

7.1 Training Authority EMT-Basic Life Support

The Mississippi Vocational-Technical Education Division of the Department of Education, with the cooperation of the Governor's Highway Safety Program, the Mississippi State Department of Health, and the American College of Surgeons-Mississippi Committee on Trauma, and the Mississippi Chapter of the American College of Emergency Physicians, offered the EMT-B training course through the Mississippi Community College System. Additionally, organized EMS districts as recognized by the DEMS, are authorized to provide this training. The Guidelines and minimum standards are set forth in order to establish a minimum level of training for the Emergency Medical Technician at the Basic level. These guidelines and minimum standards shall be met by all Basic Emergency Medical Technician Courses in the state.

7.2 EMT Basic Curriculum

EMT Basic Curriculum must conform, at minimum, to the National Standard EMT Basic: National Standard Curriculum developed by the United States Department of Transportation and current revisions as approved for use by the DEMS. Minimum hours required for EMT Basic are: 110 didactic, 12 hours of hospital emergency clinical lab and 5 documented emergency runs aboard an ambulance. Written permission from the DEMS must be obtained prior to the start of an EMT Basic Training course.

7.3 Request for Approval of EMT Basic training programs

Note: A list of DEMS approved EMT Basic training programs will be available at the DEMS office and DEMS web site.

7.3.1. Request for approval of EMT Basic training programs not contained on the approved list shall be sent to DEMS with evidence and verification that:

a.) the Community College has been approved by the Mississippi State Department of Education, Mississippi Vocational-Technical Education Division.

b.) EMT Basic training program meets, at minimum, the requirements of the National Standard EMT Basic curriculum as given in this section.

c.) EMT Basic Instructors meet the requirements of the Mississippi State Department of Education and the DEMS. There must be certification and re-certification requirements that must be met, including an evaluation of instructor terminal competencies, provided in the requested training program.

Note: Credentialed EMS Instructors of DEMS as trained through the MS EMS Instructor Training Program, and in good standing, are considered as meeting the above requirement.

7.4 EMT Basic Training Programs

7.4.1. The length of the EMT Basic course shall not be less than 110 hours didactic, 12 hours of hospital clinical lab and 5 documented emergency runs aboard an ambulance.

7.4.2. The complete EMT Basic educational program shall be designed to provide the knowledge that will allow the student to arrive at decisions based on accepted medical knowledge and that will permit the professional growth of the EMT Basic.

7.4.3. The program shall consist of, at minimum, three components: didactic and lab instruction, hospital clinical and practical evaluation on emergency runs under a medical command authority. The time required to complete each component may vary, in part being dependent on the ability of students to demonstrate their mastery of the educational objectives by written, verbal, and practical examination.

7.4.4. The program shall maintain on file, for each component of the curriculum, a reasonable comprehensive list of the terminal performance objectives to be achieved by the student. These objectives must delineate mastery in all competencies identified, including curriculum documentation, measurement techniques used, and the records maintained on each student's work.

7.4.5 The student must be informed about the methods and data used in determining grades and about the mechanism for appeal. Conditions governing dismissal from the program must be clearly defined in writing and distributed to the student at the beginning of the training program.

7.4.6 Evidence of student competence in achieving the educational objectives of the program must be kept on file. Documentation must be in the form of both written and practical examinations.

7.4.7. Classroom, clinical and optional field faculty must prepare written evaluations on each student. Documentation must be maintained identifying the counseling given to individual students regarding their performance and the recommendations maintained identifying the counseling given to individual students regarding their performance and the recommendations made to correct inadequate performance. Documentation on whether or not the student followed through on faculty recommendations should also be maintained. Instruction should be supported by performance assessments.

7.4.8. Faculty must be presented with the program's educational objectives for uses in preparation of lectures and field practicals. The course coordinator must ensure that stated educational objectives are covered and should answer any questions from students or clarify information presented by a lecturer.

a. Didactic instruction:
Lectures, discussions, and demonstrations presented by physicians and others who are competent in the field.

b. Clinical and Other Settings:
Instruction and supervised practice of emergency medical skills. Practice should not be limited to the development of practical skills alone, but should include knowledge and techniques regarding patient evaluations, development of patient rapport, and care for and understanding of the patient's illness. Documentation must be maintained for each students performance in all of the various areas. A frequent performance evaluation

is recommended.

c. A Field Experience

The field internship is a period of supervised experience in a structured overall EMS system. It provides the student with a progression of increasing patient care responsibilities which proceed from observation to working as a member of a team. There should be a provision for physician evaluation of student progress in acquiring the desired skills to be developed through this experience. The EMT Basic must have telecommunication with medical command authority. The initial position of the student on the EMS care team should be that of observer only utilizing limited learned skills. After progression through record keeping and participation in actual patient care, the student should eventually function as the patient care leader. However, the student should not be placed in the position of being a necessary part of the patient care team. The team must be able to function without the necessary use of a student who may be present.

7.4.9. General courses and topics of study must be achievement oriented and shall provide students with:

a. The ability to recognize the nature and seriousness of the patients condition or extent of injuries to access requirements for emergency medical care;

b. The ability to administer appropriate emergency medical care based on assessment findings of the patients condition;

c. Lift, move, position and otherwise handle the patient to minimize discomfort and prevent further injury; and,

d. Perform safely and effectively the expectations of the job description.

Policy for Administration

Operational Policies

Student matriculation practices and student and faculty recruitment should be non-discriminatory with respect to race, color, creed, sex or national origin. Student matriculation and student and faculty recruitment practices are to be consistent with all laws regarding non-discrimination. It is recommended that records be kept for a reasonable period of time on the number of students who apply and the number who successfully complete training.

a. Announcements and advertising about the program shall reflect accurately the training being offered.

b. The program shall be educational and students shall use their schedule time for educational experiences.

c. Health and safety for students, faculty, and patients shall be adequately safeguarded.

d. Cost to the student shall be reasonable and accurately stated and published.

e. Policies and process for student withdrawal and refunds on tuition on fees shall be fair, and made known to all applicants.

Curriculum Description

Instructional content of the educational program should include the successful completion of stated educational objectives that fulfill local and regional needs and that satisfy the requirements of this curriculum section. The curriculum should be organized to provide the student with knowledge required to understand fully the skills that are taught in this program. It is important not to loose sight of the original purpose of the EMT Basic level. The curriculum is the NSTC for the EMT Basic. Students should have an opportunity to acquire clinical experience and practical skills related to the emergency medical care of these patients. Students should also understand the ethical and legal responsibilities they assume as students are being prepared to assume as graduates.

7.4.10. All requirements given in the Guidelines and Minimum Standards related to Basic Emergency Medical Technician Training must be met.

7.5 EMT Basic classes, class approved

EMT Basic class approval forms can be requested from the DEMS or be completed on the DEMS website. Credentialed EMT Basic instructors should complete the class approval form and submit to the DEMS, at minimum, fourteen calendar days prior to the first day of class. The DEMS will assign a class number to all approved requests and return to the credentialed EMT Basic instructor. Incomplete paperwork will be returned without action.

7.6 EMT Basic classes, initial roster

Initial rosters shall be completed by the credentialed EMT Basic instructor immediately following the second meeting of the class. Initial roster forms can be obtained from the DEMS or be completed on the DEMS website. A final roster for full or refresher EMT Basic class will not be accepted without an initial roster on file with the DEMS.

7.7 EMT Basic classes, final roster

Final rosters shall be completed by the credentialed EMT Basic instructor immediately following the end of a full EMT Basic or EMT Refresher class. The final roster shall be inclusive of all students on the initial roster. The final roster will note students who withdrew, failed, and completed the EMT Basic class. The final roster form can be obtained from the DEMS or be completed on the DEMS web site. Students successfully completing the class will not be allowed to test National Registry until a final roster is on file with the DEMS.

7.8 EMT Basic Training Programs, minimum admittance criteria

7.8.1. Age of at least 18 years.
7.8.2. For other admittance criteria refer to the Guidelines and Minimum Standards related to Basic Emergency Medical Technician Training.

7.9 EMT Basic Refresher Training

EMT Basic refresher training shall consist of: the current National Standard Basic EMT Refresher Curriculum (24 hour minimum), and shall include successful completion of a local written and practical examination. EMT Basic refresher training must be accomplished by all certified EMT Basics during their National Registry certification period.

7.10. Prerequisites to certification as an EMT Basic (training obtained in Mississippi).

7.10.1. Age of at least 18 years.
7.10.2. Completion of the Board's approved Emergency Technician Training Program (Note: This includes passage of the National Registry examination).
7.10.3. Verification of medical control (Jurisdictional Medical Control Agreement)

7.11. Prerequisites to certification as an EMT-Basic (training obtained in another state)

7.11.1. Age of at least 18 years.
7.11.2. An applicant must demonstrate a need for reciprocity by submitting a Jurisdictional Medical Control Agreement from a licensed ambulance service or a facility providing basic life support service indicating the applicant is presently employed or will be employed upon moving to the state.
7.11.3. Completion of an EMT program (basic level) which meets the guidelines of the national standard curriculum. A copy of the program curriculum and educational objectives must be submitted to an approved by the DEMS.
7.11.4. Applicant must be registered as an EMT-Basic by the National Registry of EMTs. This is documented by submitting a copy of the National Registry wallet card.

7.12. EMT-Basic Certification
7.12.1. Any person desiring certification as an EMT-Basic shall apply to DEMS using forms provided (Application for state certification)
7.12.2. All certification applications must be accompanied by fifteen dollar ($15.00) money order payable to the Mississippi State Department of Health. Also include copy of current National Registry card and a Jurisdictional Medical Control Agreement.
7.12.3. The DEMS may withhold or deny an application for certification for a like period of time equal to the period of time under which a person failed to comply. Mississippi requires that all EMT-Basics maintain current registration with the National Registry of Emergency Medical Technicians.

7.13. EMT-Basic Re-certification
7.13.1. Any person desiring re-certification as an EMT-Basic shall apply to DEMS using forms provided (Application for state certification)
7.13.2. All re-certification applications must be accompanied by fifteen dollar ($15.00) money order payable to the Mississippi State Department of Health. Also include copy of current National Registry card and a Jurisdictional Medical Control Agreement.
7.13.3. All EMT's failing to re-certify with DEMS on or before the expiration date of his/her certification period will be considered officially expired.

7.13.2. DEMS may withhold or deny an application for re-certification for a like period of time equal to the like period of time under which a person fails to comply.

7.14. EMT Basic, Grounds for Suspension or Revocation.

7.14.1. Fraud or any mis-statement of fact in the procurement of any certifications or in any other statement of representation to the Board or its representatives.

7.14.2. Gross negligence.

7.14.3. Repeated negligent acts.

7.14.4. Incompetence.

7.14.5. Disturbing the peace while on duty

7.14.6. Disregarding the speed regulations prescribed by law while on duty.

7.14.7. Failure to carry the Mississippi State Department of Health issued certification card while on duty or failure to wear appropriate identification as approved by the DEMS.

7.14.8. Failure to maintain current registration by the National Registry of EMTs.

7.14.9. Failure to maintain all current EMT-Basic training standards as required by the DEMS.

7.14.10. The commission of any fraudulent dishonest, or corrupt act which is substantially related to the qualifications, functions, and duties of pre-hospital personnel.

7.14.11. Conviction of any crime which is substantially related to the qualification, functions, and duties of pre-hospital personnel. The record of conviction or certified copy thereof will be conclusive evidence of such conviction.

7.14.12. Violating or attempting to violate directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this part of the regulations promulgated by the DEMS, pertaining to pre-hospital personnel.

7.14.13. Violating or attempting to violate any federal or state statute or regulation which regulates narcotics, dangerous drugs, or controlled substances.

7.14.14. Addiction to, excessive use of, or misuse of, alcoholic beverages, narcotics, dangerous drugs, or controlled substances.

7.14.15. Functioning outside the supervision of medical control in the field care system operating at the local level, except as authorized by certification and license issued to the BLS provider.

7.14.16. Permitting, aiding or abetting an unlicenced or uncertified person to perform activities requiring a license or certification.

7.14.17. Suspension or revocation of any DEMS issued certification may effect other DEMS issued certifications at all levels.

Policy for Administration

Description of the Occupation and Competency of the EMT-Basic

"The EMT's Primary responsibility is to bring expert emergency medical care to the victims of emergencies and to transport them safely and expeditiously to the proper facility." The EMT-B must accomplish these duties unsupervised, in a great variety of circumstances and often under considerable physical and emotional stress. The concept of an emergency medical technician, therefore, is of a person capable of exercising technical skills with authority and good judgement

under difficult and stressful conditions. Personal qualities of stability, leadership and judgement are primary. It must also be stressed that ongoing medical control and evaluation of the functioning EMT is essential to the maintenance of medical care quality. As with all professionals in the medical community, it must be realized that continuing education is an integral part of the EMT's ability to maintain a high degree of competence.

Job Summary

A Mississippi EMT-Basic responds to emergency calls to provide efficient and immediate care to the critically ill and injured, and transports the patient to a medical facility.

After receiving the call from the dispatcher, drives the ambulance to address or location given, using the most expeditious route, depending on the traffic and weather conditions. Observes traffic ordinances and regulations concerning emergency vehicle operations.

Upon arrival at the scene of the crash or illness, parks the ambulance in a safe location to avoid additional injury. Prior to initiating patient care, the EMT-Basic will also "size-up" the scene to determine that the scene is safe, the mechanism of injury or nature of illness, total number of patients, and to request additional help if necessary. In the absence of law enforcement, creates a safe traffic environment, such as the placement of road warning devices, removal of debris and re-direction of traffic for the protection of the injured and those assisting in the care of injured patients.

Determines the nature and extent of illness or injury and establishes priority for required emergency care. Based on assessment findings, renders emergency medical care to adult, infant and child, medical and trauma patients. Duties include, but are not limited to, opening and maintaining an airway, ventilating patients and cardiopulmonary resuscitation, including use of Automated External Defibrillators. Provide pre-hospital emergency medical care of simple and multiple system trauma such as controlling hemorrhage, treatment of shock (hypoperfusion), bandaging wounds, and immobilization of painful, swollen, deformed extremities. Medical patients include: Assisting in childbirth, management of respiratory, cardiac, diabetic, allergic, behavioral, and environmental emergencies, and suspected poisonings. Searches for medical identification emblem as a clue in providing emergency care. Additional care is provided based upon assessment of the patient and obtaining historical information. These interventions, include assisting patients with prescribed medications, including sublingual nitroglycerine, epinephrine auto-injectors and hand-held aerosol inhalers. The EMT-Basic will also be responsible for administration of Oxygen, oral glucose, and activated charcoal.

Reassures patients and bystanders by working in a confident, efficient manner. Avoids mishandling and undue haste while working expeditiously to accomplish

the task.

Where a patient be extricated from entrapment, assesses the extent of injury and gives all possible emergency care and protection to the entrapped patient and uses the prescribed techniques and appliances for safely removing the patient. If needed, radios the dispatcher for additional help or special rescue and/or utility services. Provides simple rescue service if the ambulance has not been accompanied by a specialized unit. After extrication, provides additional care in triaging the injured in accordance with standard emergency procedures.

Complies with regulations on the handling of the deceased, notifies authorities, and arranges for protection of property and evidence at scene.

Lifts stretcher, placing in ambulance and seeing that the patient and the stretcher are secure, continues emergency medical care.

From the knowledge of the condition of the patient and the extent of injuries and the relative locations and staffing of emergency hospital facilities, determines the most appropriate facility to which the patient will be transported, unless otherwise directed by medical control plan or director. Reports directly to the emergency department or communications center the nature and extent of injuries, the number being transported, and the destination to assure prompt medical care on arrival. Identifies assessment findings which may require communications with medical direction for advice and for notification that special professional services and assistance be immediately available upon arrival at the medical facility.

Constantly assesses patient en route to emergency facility, administers additional care as indicated or directed by medical direction.

Assists in lifting and carrying the patient out of the ambulance and into the receiving facility.

Reports verbally and in writing their observation and emergency medical care of the patient at the emergency scene and in transit to the receiving facility staff for purposes of records and diagnostics. Upon request, provides assistance to the receiving facility's staff.

After each call, restocks and replaces used linens, blankets and other supplies, cleans all equipment following appropriate disinfecting procedures, makes careful check of all equipment so that the ambulance is ready for the next run. Maintains ambulance in efficient operating condition. Ensures that the ambulance is cleaned and washed and kept in a neat orderly condition. In accordance with local, state or federal regulations, decontaminates the interior of the vehicle after transport of patient with contagious infection or hazardous materials exposure.

Determines that vehicle is in proper mechanical condition by checking items required by service management. Maintains familiarity with specialized

equipment used by the service.

Attends continuing education and refresher training programs as required by employers, medical direction, licensing, or certifying agencies.

Meets qualifications within the functional job analysis.

Functional Job Analysis

EMT Basics work as part of a team. Thorough knowledge of theoretical procedures and ability to integrate knowledge and performance into practical situations are critical. Self-confidence, emotional stability, good judgement, tolerance for high stress, and a pleasant personality are also essential characteristics of a successful EMT-Basic at any level. EMT-Basics also must be able to deal with adverse social situations, which include responding to calls in areas having high crime rates.

Physical demands

Aptitudes required for work of this nature are good physical stamina, endurance, and body condition which would not be adversely effected by lifting, carrying and balancing at times, patients in excess of 125 lbs. (250, with assistance). EMT-Basic must be able to work twenty-four-hour shifts. Motor coordination is necessary for the well-being of the patients, the EMT-Basic, and co-worker over uneven terrain.

7.16. Performance Standards for Emergency Medical Technician-Basic.

The EMT-Basic who functions within the State of Mississippi must be able to demonstrate the following skills and understand the elements of total emergency care to the satisfaction of the local training coordinator and the DEMS. Training programs must be approved by the DEMS. The skills listed herein will enable the basic level EMT-Basic to carry out all EMT-Basic level patient assessment and emergency care procedures.

Policy for Administration

The skills listed herein will enable the basic level EMT to carry out all EMT level patient assessment and emergency care procedures.

1. Assess areas of personal attitude and conduct of the EMT-Basic.
2. Characterize the various methods used to access the EMS system in your community.
3. List possible emotional reactions that the EMT-Basic may experience when faced with trauma, illness, death and dying.
4. Discuss the possible reactions that a family member may exhibit when confronted with death and dying.
5. State the steps in the EMT-Basic's approach to the family confronted with death

and dying.

6. State the possible reactions that the family of the EMT-Basic may exhibit due to their outside involvement in EMS.
7. Recognize the signs and symptoms of critical incident stress.
8. State possible steps that the EMT-Basic may take to help reduce/alleviate stress.
9. Explain the need to determine scene safety.
10. Discuss the importance of body substance isolation (BSI).
11. Describe the steps the EMT-Basic should take for personal protection from airborne and blood borne pathogens.
12. List the personal protective equipment necessary for each of the following situations:
    - Hazardous materials
    - Rescue operations
    - Violent scenes
    - Crime scenes
    - Exposure to blood borne pathogens
    - Exposure to airborne pathogens
13. Explain the rationale for serving as an advocate for the use of appropriate protective equipment.
14. Given a scenario with potential infectious exposure, the EMT-Basic will use appropriate personal protective equipment. At the completion of the scenario, the EMT-Basic will properly remove and discard the protective garments.
15. Given the above scenario, the EMT-Basic will complete disinfection/cleaning and all reporting documentation.
16. Define the EMT-Basic scope of practice.
17. Discuss the importance of Do Not Resuscitate [DNR] (advance directives) and local or state provisions regarding EMS application.
18. Define consent and discuss the methods of obtaining consent.
19. Differentiate between expressed and implied consent.
20. Explain the role of consent of minors in providing care.
21. Discuss the implications for the EMT-Basic in patient refusal of transport.
22. Discuss the issues of abandonment, negligence, and battery and their implications to the EMT-Basic.
23. State the conditions necessary for the EMT-Basic to have a duty to act.
24. Explain the importance, necessity and legality of patient confidentiality.
25. Discuss the considerations of the EMT-Basic in issues of organ retrieval.
26. Differentiate the actions that an EMT-Basic should take to assist in the preservation of a crime scene.
27. State the conditions that require an EMT-Basic to notify local law enforcement officials.
28. Explain the role of EMS and the EMT-Basic regarding patients with DNR orders.
29. Explain the rationale for the needs, benefits and usage of advance directives.
30. Explain the rationale for the concept of varying degrees of DNR.
31. Identify the following topographic terms: medial, lateral, proximal, distal, superior, inferior, anterior, posterior, midline, right and left, mid-clavicular, bilateral, mid-axillary.
32. Describe the anatomy and function of the following major body systems:

Respiratory, circulatory, musculoskeletal, nervous and endocrine.

33. Identify the components of the extended vital signs.
34. Describe the methods to obtain a breathing rate.
35. Identify the attributes that should be obtained when assessing breathing.
36. Differentiate between shallow, labored and noisy breathing.
37. Describe the methods to obtain a pulse rate.
38. Identify the information obtained when assessing a patient's pulse.
39. Differentiate between a strong, weak, regular and irregular pulse.
40. Describe the methods to assess the skin color, temperature, condition (capillary refill in infants and children).
41. Identify the normal and abnormal skin colors.
42. Differentiate between pale, blue, red and yellow skin color.
43. Identify the normal and abnormal skin temperature.
44. Differentiate between hot, cool and cold skin temperature.
45. Identify normal and abnormal skin conditions.
46. Identify normal and abnormal capillary refill in infants and children.
47. Describe the methods to assess the pupils.
48. Identify normal and abnormal pupil size.
49. Differentiate between dilated (big) and constricted (small) pupil size.
50. Differentiate between reactive and non-reactive pupils and equal and unequal pupils.
51. Describe the methods to assess blood pressure.
52. Define systolic pressure.
53. Define diastolic pressure.
54. Explain the difference between auscultation and palpation for obtaining a blood pressure.
55. Identify the components of the SAMPLE history.
56. Differentiate between a sign and a symptom.
57. State the importance of accurately reporting and recording the baseline vital signs.
58. Discuss the need to search for additional medical identification.
59. Explain the value of performing the baseline vital signs.
60. Recognize and respond to the feelings patients experience during assessment.
61. Defend the need for obtaining and recording an accurate set of vital signs.
62. Explain the rationale of recording additional sets of vital signs.
63. Explain the importance of obtaining a SAMPLE history.
64. Demonstrate the skills involved in assessment of breathing.
65. Demonstrate the skills associated with obtaining a pulse.
66. Demonstrate the skills associated with assessing the skin color, temperature, condition, and capillary refill in infants and children.
67. Demonstrate the skills associated with assessing the pupils.
68. Demonstrate the skills associated with obtaining blood pressure.
69. Demonstrate the skills that should be used to obtain information from the patient, family, or bystanders at the scene.
70. Define body mechanics.
71. Discuss the guidelines and safety precautions that need to be followed when lifting a patient.
72. Describe the safe lifting of cots and stretchers.

73. Describe the guidelines and safety precautions for carrying patients and/or equipment.
74. Discuss one-handed carrying techniques.
75. Describe correct and safe carrying procedures on stairs.
76. State the guidelines for reaching and their application.
77. Describe correct reaching for log rolls.
78. State the guidelines for pushing and pulling.
79. Discuss the general considerations of moving patients.
80. State three situations that may require the use of an emergency move.
81. Identify the following patient carrying devices:
    - Wheeled ambulance stretcher
    - Portable ambulance stretcher
    - Stair chair
    - Scoop stretcher
    - Long spine board
    - Basket stretcher
    - Flexible stretcher
82. Explain the rationale for properly lifting and moving patients.
83. Working with a partner, prepare each of the following devices for use, transfer a patient to the device, properly position the patient on the device, move the device to the ambulance and load the patient into the ambulance:
    - Wheeled ambulance stretcher
    - Portable ambulance stretcher
    - Stair chair
    - Scoop stretcher
    - Long spine board
    - Basket stretcher
    - Flexible stretcher
84. Working with a partner, the EMT-Basic will demonstrate techniques for the transfer of a patient from an ambulance stretcher to a hospital stretcher.
85. Name and label the major structures of the respiratory system on a diagram.
86. List the signs of adequate breathing.
87. List the signs of inadequate breathing.
88. Describe the steps in performing the head-tilt chin-lift.
89. Relate mechanism of injury to opening the airway.
90. Describe the steps in performing the jaw thrust.
91. State the importance of having a suction unit ready for immediate use when providing emergency care.
92. Describe the techniques of suctioning.
93. Describe how to artificially ventilate a patient with a pocket mask.
94. Describe the steps in performing the skill of artificially ventilating a patient with a bag-valve-mask while using the jaw thrust.
95. List the parts of a bag-valve-mask system.
96. Describe the steps in performing the skill of artificially ventilating a patient with a bag-valve-mask for one and two rescuers.
97. Describe the signs of adequate artificial ventilation using the bag-valve-mask.
98. Describe the signs of inadequate artificial ventilation using the bag-valve-mask.

99. Describe the steps in artificially ventilating a patient with a flow restricted, oxygen-powered ventilation device.
100. List the steps in performing the actions taken when providing mouth-to-mouth and mouth-to-stoma artificial ventilation.
101. Describe how to measure and insert an oropharyngeal (oral) airway.
102. Describe how to measure and insert a nasopharyngeal (nasal) airway.
103. Define the components of an oxygen delivery system.
104. Identify a nonrebreather face mask and state the oxygen flow requirements needed for its use.
105. Describe the indications for using a nasal cannula versus a nonrebreather face mask.
106. Identify a nasal cannula and state the flow requirements needed for its use.
107. Explain the rationale for basic life support artificial ventilation and airway protective skills taking priority over most other basic life support skills.
108. Explain the rationale for providing adequate oxygenation through high inspired oxygen concentrations to patients who, in the past, may have received low concentrations.
109. Demonstrate the steps in performing the head-tilt chin-lift.
110. Demonstrate the steps in performing the jaw thrust.
111. Demonstrate the techniques of suctioning.
112. Demonstrate the steps in providing mouth-to-mouth artificial ventilation with body substance isolation (barrier shields).
113. Demonstrate how to use a pocket mask to artificially ventilate a patient.
114. Demonstrate the assembly of a bag-valve-mask unit.
115. Demonstrate the steps in performing the skill of artificially ventilating a patient with a bag-valve-mask for one and two rescuers.
116. Demonstrate the steps in performing the skill of artificially ventilating a patient with a bag-valve-mask while using the jaw thrust.
117. Demonstrate artificial ventilation of a patient with a flow restricted, oxygen-powered ventilation device.
118. Demonstrate how to artificially ventilate a patient with a stoma.
119. Demonstrate how to insert an oropharyngeal (oral) airway.
120. Demonstrate how to insert a nasopharyngeal (nasal) airway.
121. Demonstrate the correct operation of oxygen tanks and regulators.
122. Demonstrate the use of a nonrebreather face mask and state the oxygen flow requirements needed for its use.
123. Demonstrate the use of a nasal cannula and state the flow requirements needed for its use.
124. Demonstrate how to artificially ventilate the infant and child patient.
125. Demonstrate oxygen administration for the infant and child patient.
126. Recognize hazards/potential hazards.
127. Describe common hazards found at the scene of a trauma and a medical patient.
128. Determine if the scene is safe to enter.
129. Discuss common mechanisms of injury/nature of illness.
130. Discuss the reason for identifying the total number of patients at the scene.
131. Explain the reason for identifying the need for additional help or assistance.
132. Explain the rationale for crew members to evaluate scene safety prior to entering.

133. Serve as a model for others explaining how patient situations affect your evaluation of mechanism of injury or illness.
134. Observe various scenarios and identify potential hazards.
135. Summarize the reasons for forming a general impression of the patient.
136. Discuss methods of assessing altered mental status.
137. Differentiate between assessing the altered mental status in the adult, child and infant patient.
138. Discuss methods of assessing the airway in the adult, child and infant patient.
139. State reasons for management of the cervical spine once the patient has been determined to be a trauma patient.
140. Describe methods used for assessing if a patient is breathing.
141. State what care should be provided to the adult, child and infant patient with adequate breathing.
142. State what care should be provided to the adult, child and infant patient without adequate breathing.
143. Differentiate between a patient with adequate and inadequate breathing.
144. Distinguish between methods of assessing breathing in the adult, child and infant patient.
145. Compare the methods of providing airway care to the adult, child and infant patient.
146. Describe the methods used to obtain a pulse.
147. Differentiate between obtaining a pulse in an adult, child and infant patient.
148. Discuss the need for assessing the patient for external bleeding.
149. Describe normal and abnormal findings when assessing skin color.
150. Describe normal and abnormal findings when assessing skin temperature.
151. Describe normal and abnormal findings when assessing skin condition.
152. Describe normal and abnormal findings when assessing skin capillary refill in the infant and child patient.
153. Explain the reason for prioritizing a patient for care and transport.
154. Explain the importance of forming a general impression of the patient.
155. Explain the value of performing an initial assessment.
156. Demonstrate the techniques for assessing mental status.
157. Demonstrate the techniques for assessing the airway.
158. Demonstrate the techniques for assessing if the patient is breathing.
159. Demonstrate the techniques for assessing if the patient has a pulse.
160. Demonstrate the techniques for assessing the patient for external bleeding.
161. Demonstrate the techniques for assessing the patient's skin color, temperature, condition and capillary refill (infants and children only).
162. Demonstrate the ability to prioritize patients.
163. Discuss the reasons for reconsideration concerning the mechanism of injury.
164. State the reasons for performing a rapid trauma assessment.
165. Recite examples and explain why patients should receive a rapid trauma assessment.
166. Describe the areas included in the rapid trauma assessment and discuss what should be evaluated.
167. Differentiate when the rapid assessment may be altered in order to provide patient care.

168. Discuss the reason for performing a focused history and physical exam.
169. Recognize and respect the feelings that patients might experience during assessment.
170. Demonstrate the rapid trauma assessment that should be used to assess a patient based on mechanism of injury.
171. Describe the unique needs for assessing an individual with a specific chief complaint with no known prior history.
172. Differentiate between the history and physical exam that is performed for responsive patients with no known prior history and patients responsive with a known prior history.
173. Describe the unique needs for assessing an individual who is unresponsive or has an altered mental status.
174. Differentiate between the assessment that is performed for a patient who is unresponsive or has an altered mental status and other medical patients requiring assessment.
175. Attend to the feelings that these patients might be experiencing.
176. Demonstrate the patient care skills that should be used to assist with a patient who is responsive with no known history.
177. Demonstrate the patient care skills that should be used to assist with a patient who is unresponsive or has an altered metal status.
178. Discuss the components of the detailed physical exam.
179. State the areas of the body that are evaluated during the detailed physical exam.
180. Explain what additional care should be provided while performing the detailed physical exam.
181. Distinguish between the detailed physical exam that is performed on a trauma patient and that of the medical patient.
182. Explain the rationale for the feelings that these patients might be experiencing.
183. Demonstrate the skills involved in performing the detailed physical exam.
184. Discuss the reasons for repeating the initial assessment as part of the on-going assessment.
185. Describe the components of the on-going assessment.
186. Describe trending of assessment components.
187. Explain the value of performing an on-going assessment.
188. Recognize and respect the feelings that patients might experience during assessment.
189. Explain the value of trending assessment components to other health professionals who assume care of the patient.
190. Demonstrate the skills involved in performing the on-going assessment.
191. List the proper methods of initiating and terminating a radio call.
192. State the proper sequence for delivery of patient information.
193. Explain the importance of effective communication of patient information in the verbal report.
194. Identify the essential components of the verbal report.
195. Describe the attributes for increasing effectiveness and efficiency of verbal communications.
196. State legal aspects to consider in verbal communication.
197. Discuss the communication skills that should be used to interact with the patient.

198. Discuss the communication skills that should be used to interact with the family, bystanders, individuals from other agencies while providing patient care and the difference between skills used to interact with the patient and those used to interact with others.
199. List the correct radio procedures in the following phases of a typical call:
    - To the scene.
    - At the scene.
    - To the facility.
    - At the facility.
    - To the station.
    - At the station.
200. Explain the rationale for providing efficient and effective radio communications and patient reports.
201. Perform a simulated, organized, concise radio transmission.
202. Perform an organized, concise patient report that would be given to the staff at a receiving facility.
203. Perform a brief, organized report that would be given to an ALS provider arriving at an incident scene at which the EMT-Basic was already providing care.
204. Explain the components of the written report and list the information that should be included on the written report.
205. Identify the various sections of the written report.
206. Describe what information is required in each section of the prehospital care report and how it should be entered.
207. Define the special considerations concerning patient refusal.
208. Describe the legal implications associated with the written report.
209. Discuss all state and/or local record and reporting requirements.
210. Explain the rationale for patient care documentation.
211. Explain the rationale for the EMS system gathering data.
212. Explain the rationale for using medical terminology correctly.
213. Explain the rationale for using an accurate and synchronous clock so that information can be used in trending.
214. Complete a prehospital care report.
215. Identify which medications will be carried on the unit.
216. State the medications carried on the unit by the generic name.
217. Identify the medications with which the EMT-B may assist the patient with administering.
218. State the medications the EMT-B can assist the patient with by the generic name.
219. Discuss the forms in which the medications may be found.
220. Explain the rationale for the administration of medications.
221. Demonstrate general steps for assisting patient with self administration of medications.
222. Read the labels and inspect each type of medication.
223. List the structure and function of the respiratory system.
224. State the signs and symptoms of a patient with breathing difficulty.
225. Describe the emergency medical care of the patient with breathing difficulty.
226. Recognize the need for medical direction to assist in the emergency medical care of the patient with breathing difficulty.

227. Describe the emergency medical care of the patient with breathing distress.
228. Establish the relationship between airway management and the patient with breathing difficulty.
229. List signs of adequate air exchange.
230. State the generic name, medication forms, dose, administration, action, indications and contraindications for the prescribed inhaler.
231. Distinguish between the emergency medical care of the infant, child and adult patient with breathing difficulty.
232. Differentiate between upper airway obstruction and lower airway disease in the infant and child patient.
233. Defend EMT-Basic treatment regimens for various respiratory emergencies.
234. Explain the rationale for administering an inhaler.
235. Demonstrate the emergency medical care for breathing difficulty.
236. Perform the steps in facilitating the use of an inhaler.

237. Describe the structure and function of the cardiovascular system.
238. Describe the emergency medical care of the patient experiencing chest pain/discomfort.
239. List the indications for automated external defibrillation (AED).
240. List the contraindications for automated external defibrillation.
241. Define the role of EMT-B in the emergency cardiac care system.
242. Explain the impact of age and weight on defibrillation.
243. Discuss the position of comfort for patients with various cardiac emergencies.
244. Establish the relationship between airway management and the patient with cardiovascular compromise.
245. Predict the relationship between the patient experiencing cardiovascular compromise and basic life support.
246. Discuss the fundamentals of early defibrillation.
247. Explain the rationale for early defibrillation.
248. Explain that not all chest pain patients result in cardiac arrest and do not need to be attached to an automated external defibrillator.
249. Explain the importance of prehospital ACLS intervention if it is available.
250. Explain the importance of urgent transport to a facility with Advanced Cardiac Life Support if it is not available in the prehospital setting.
251. Discuss the various types of automated external defibrillators.
252. Differentiate between the fully automated and the semiautomated defibrillator.
253. Discuss the procedures that must be taken into consideration for standard operations of the various types of automated external defibrillators.
254. State the reasons for assuring that the patient is pulseless and apneic when using the automated external defibrillator.
255. Discuss the circumstances which may result in inappropriate shocks.
256. Explain the considerations for interruption of CPR, when using the automated external defibrillator.
257. Discuss the advantages and disadvantages of automated external defibrillators.
258. Summarize the speed of operation of automated external defibrillation.
259. Discuss the use of remote defibrillation through adhesive pads.
260. Discuss the special considerations for rhythm monitoring.

261. List the steps in the operation of the automated external defibrillator.
262. Discuss the standard of care that should be used to provide care to a patient with persistent ventricular fibrillation and no available ACLS.
263. Discuss the standard of care that should be used to provide care to a patient with recurrent ventricular fibrillation and no available ACLS.
264. Differentiate between the single rescuer and multi-rescuer care with an automated external defibrillator.
265. Explain the reason for pulses not being checked between shocks with an automated external defibrillator.
266. Discuss the importance of coordinating ACLS trained providers with personnel using automated external defibrillators.
267. Discuss the importance of post-resuscitation care.
268. List the components of post-resuscitation care.
269. Explain the importance of frequent practice with the automated external defibrillator.
270. Discuss the need to complete the Automated Defibrillator: Operator's Shift Checklist.
271. Discuss the role of the American Heart Association (AHA) in the use of automated external defibrillation.
272. Explain the role medical direction plays in the use of automated external defibrillation.
273. State the reasons why a case review should be completed following the use of the automated external defibrillator.
274. Discuss the components that should be included in a case review.
275. Discuss the goal of quality improvement in automated external defibrillation.
276. Recognize the need for medical direction of protocols to assist in the emergency medical care of the patient with chest pain.
277. List the indications for the use of nitroglycerin.
278. State the contraindications and side effects for the use of nitroglycerin.
279. Define the function of all controls on an automated external defibrillator, and describe event documentation and battery defibrillator maintenance.
280. Defend the reasons for obtaining initial training in automated external defibrillation and the importance of continuing education.
281. Defend the reason for maintenance of automated external defibrillators.
282. Explain the rationale for administering nitroglycerin to a patient with chest pain or discomfort.
283. Demonstrate the assessment and emergency medical care of a patient experiencing chest pain/discomfort.
284. Demonstrate the application and operation of the automated external defibrillator.
285. Demonstrate the maintenance of an automated external defibrillator.
286. Demonstrate the assessment and documentation of patient response to the automated external defibrillator.
287. Demonstrate the skills necessary to complete the Automated Defibrillator: Operator's Shift Checklist.
288. Perform the steps in facilitating the use of nitroglycerin for chest pain or discomfort.
289. Demonstrate the assessment and documentation of patient response to

nitroglycerin.

290. Practice completing a prehospital care report for patients with cardiac emergencies.
291. Identify the patient taking diabetic medications with altered mental status and the implications of a diabetes history.
292. State the steps in the emergency medical care of the patient taking diabetic medicine with an altered mental status and a history of diabetes.
293. Establish the relationship between airway management and the patient with altered mental status.
294. State the generic and trade names, medication forms, dose, administration, action, and contraindications for oral glucose.
295. Evaluate the need for medical direction in the emergency medical care of the diabetic patient.
296. Explain the rationale for administering oral glucose.
297. Demonstrate the steps in the emergency medical care for the patient taking diabetic medicine with an altered mental status and a history of diabetes.
298. Demonstrate the steps in the administration of oral glucose.
299. Demonstrate the assessment and documentation of patient response to oral glucose.
300. Demonstrate how to complete a prehospital care report for patients with diabetic emergencies.
301. Recognize the patient experiencing an allergic reaction.
302. Describe the emergency medical care of the patient with an allergic reaction.
303. Establish the relationship between the patient with an allergic reaction and airway management.
304. Describe the mechanisms of allergic response and the implications for airway management.
305. State the generic and trade names, medication forms, dose, administration, action, and contraindications for the epinephrine auto-injector.
306. Evaluate the need for medical direction in the emergency medical care of the patient with an allergic reaction.
307. Differentiate between the general category of those patients having an allergic reaction and those patients having an allergic reaction and requiring immediate medical care, including immediate use of epinephrine auto-injector.
308. Explain the rationale for administering epinephrine using an auto-injector.
309. Demonstrate the emergency medical care of the patient experiencing an allergic reaction.
310. Demonstrate the use of epinephrine auto-injector.
311. Demonstrate the assessment and documentation of patient response to an epinephrine injection.
312. Demonstrate proper disposal of equipment.
313. Demonstrate completing a prehospital care report for patients with allergic emergencies.
314. List various ways that poisons enter the body.
315. List signs/symptoms associated with poisoning.
316. Discuss the emergency medical care for the patient with possible overdose.
317. Describe the steps in the emergency medical care for the patient with suspected

poisoning.

318. Establish the relationship between the patient suffering from poisoning or overdose and airway management.
319. State the generic and trade names, indications, contraindications, medication form, dose, administration, actions, side effects and re-assessment strategies for activated charcoal.
320. Recognize the need for medical direction in caring for the patient with poisoning or overdose.
321. Explain the rationale for administering activated charcoal.
322. Explain the rationale for contacting medical direction early in the prehospital management of the poisoning or overdose patient.
323. Demonstrate the steps in the emergency medical care for the patient with possible overdose.
324. Demonstrate the steps in the emergency medical care for the patient with suspected poisoning.
325. Perform the necessary steps required to provide a patient with activated charcoal.
326. Demonstrate the assessment and documentation of patient response.
327. Demonstrate proper disposal of administration of activated charcoal equipment.
328. Demonstrate completing a prehospital care report for patients with a poisoning/overdose emergency.
329. Describe the various ways that the body loses heat.
330. List the signs and symptoms of exposure to cold.
331. Explain the steps in providing emergency medical care to a patient exposed to cold.
332. List the signs and symptoms of exposure to heat.
333. Explain the steps in providing emergency care to a patient exposed to heat.
334. Recognize the signs and symptoms of water-related emergencies.
335. Describe the complications of near drowning.
336. Discuss the emergency medical care of bites and stings.
337. Demonstrate the assessment and emergency medical care of a patient with exposure to cold.
338. Demonstrate the assessment and emergency medical care of a patient with exposure to heat.
339. Demonstrate the assessment and emergency medical care of a near drowning patient.
340. Demonstrate completing a prehospital care report for patients with environmental emergencies.
341. Define behavioral emergencies.
342. Discuss the general factors that may cause an alteration in a patient's behavior.
343. State the various reasons for psychological crises.
344. Discuss the characteristics of an individual's behavior which suggests that the patient is at risk for suicide.
345. Discuss special medical/legal considerations for managing behavioral emergencies.
346. Discuss the special considerations for assessing a patient with behavioral problems.
347. Discuss the general principles of an individual's behavior which suggests that he is

at risk for violence.

348. Discuss methods to calm behavioral emergency patients.
349. Explain the rationale for learning how to modify your behavior toward the patient with a behavioral emergency.
350. Demonstrate the assessment and emergency medical care of the patient experiencing a behavioral emergency.
351. Demonstrate various techniques to safely restrain a patient with a behavioral problem.
352. Identify the following structures: Uterus, vagina, fetus, placenta, umbilical cord, amniotic sac, perineum.
353. Identify and explain the use of the contents of an obstetrics kit.
354. Identify predelivery emergencies.
355. State indications of an imminent delivery.
356. Differentiate the emergency medical care provided to a patient with predelivery emergencies from a normal delivery.
357. State the steps in the predelivery preparation of the mother.
358. Establish the relationship between body substance isolation and childbirth.
359. State the steps to assist in the delivery.
360. Describe care of the baby as the head appears.
361. Describe how and when to cut the umbilical cord.
362. Discuss the steps in the delivery of the placenta.
363. List the steps in the emergency medical care of the mother post-delivery.
364. Summarize neonatal resuscitation procedures.
365. Describe the procedures for the following abnormal deliveries: Breech birth, prolapsed cord, limb presentation.
366. Differentiate the special considerations for multiple births.
367. Describe special considerations of meconium.
368. Describe special considerations of a premature baby.
369. Discuss the emergency medical care of a patient with a gynecological emergency.
370. Explain the rationale for understanding the implications of treating two patients (mother and baby).
371. Demonstrate the steps to assist in the normal cephalic delivery.
372. Demonstrate necessary care procedures of the fetus as the head appears.
373. Demonstrate infant neonatal procedures.
374. Demonstrate post delivery care of infant.
375. Demonstrate how and when to cut the umbilical cord.
376. Attend to the steps in the delivery of the placenta.
377. Demonstrate the post-delivery care of the mother.
378. Demonstrate the procedures for the following abnormal deliveries: vaginal bleeding, breech birth, prolapsed cord, limb presentation.
379. Demonstrate the steps in the emergency medical care of the mother with excessive bleeding.
380. Demonstrate completing a prehospital care report for patients with obstetrical/gynecological emergencies.
381. List the structure and function of the circulatory system.
382. Differentiate between arterial, venous and capillary bleeding.
383. State methods of emergency medical care of external bleeding.

384. Establish the relationship between body substance isolation and bleeding.
385. Establish the relationship between airway management and the trauma patient.
386. Establish the relationship between mechanism of injury and internal bleeding.
387. List the signs of internal bleeding.
388. List the steps in the emergency medical care of the patient with signs and symptoms of internal bleeding.
389. List signs and symptoms of shock (hypoperfusion).
390. State the steps in the emergency medical care of the patient with signs and symptoms of shock (hypoperfusion).
391. Explain the sense of urgency to transport patients that are bleeding and show signs of shock (hypoperfusion).
392. Demonstrate direct pressure as a method of emergency medical care of external bleeding.
393. Demonstrate the use of diffuse pressure as a method of emergency medical care of external bleeding.
394. Demonstrate the use of pressure points and tourniquets as a method of emergency medical care of external bleeding.
395. Demonstrate the care of the patient exhibiting signs and symptoms of internal bleeding.
396. Demonstrate the care of the patient exhibiting signs and symptoms of shock (hypoperfusion).
397. Demonstrate completing a prehospital care report for patient with bleeding and/or shock (hypoperfusion).
398. State the major functions of the skin.
399. List the layers of the skin.
400. Establish the relationship between body substance isolation (BSI) and soft tissue injuries.
401. List the types of closed soft tissue injuries.
402. Describe the emergency medical care of the patient with a closed soft tissue injury.
403. State the types of open soft tissue injuries.
404. Describe the emergency medical care of the patient with an open soft tissue injury.
405. Discuss the emergency medical care considerations for a patient with a penetrating chest injury.
406. State the emergency medical care considerations for a patient with an open wound to the abdomen.
407. Differentiate the care of an open wound to the chest from an open wound to the abdomen.
408. List the classifications of burns.
409. Define superficial burn.
410. List the characteristics of a superficial burn.
411. Define partial thickness burn.
412. List the characteristics of a partial thickness burn.
413. Define full thickness burn.
414. List the characteristics of a full thickness burn.
415. Describe the emergency medical care of the patient with a superficial burn.
416. Describe the emergency medical care of the patient with a partial thickness burn.
417. Describe the emergency medical care of the patient with a full thickness burn.

418. List the functions of dressing and bandaging.
419. Describe the purpose of a bandage.
420. Describe the steps in applying a pressure dressing.
421. Establish the relationship between airway management and the patient with chest injury, burns, blunt and penetrating injuries.
422. Describe the effects of improperly applied dressings, splints and tourniquets.
423. Describe the emergency medical care of a patient with an impaled object.
424. Describe the emergency medical care of a patient with an amputation.
425. Describe the emergency care for a chemical burn.
426. Describe the emergency care for an electrical burn.
427. Demonstrate the steps in the emergency medical care of closed soft tissue injuries.
428. Demonstrate the steps in the emergency medical care of open soft tissue injuries.
429. Demonstrate the steps in the emergency medical care of a patient with an open chest wound.
430. Demonstrate the steps in the emergency medical care of a patient with open abdominal wounds.
431. Demonstrate the steps in the emergency medical care of a patient with an impaled object.
432. Demonstrate the steps in the emergency medical care of a patient with an amputation.
433. Demonstrate the steps in the emergency medical care of an amputated part.
434. Demonstrate the steps in the emergency medical care of a patient with superficial burns.
435. Demonstrate the steps in the emergency medical care of a patient with partial thickness burns.
436. Demonstrate the steps in the emergency medical care of a patient with full thickness burns.
437. Demonstrate the steps in the emergency medical care of a patient with a chemical burn.
438. Demonstrate completing a prehospital care report for patients with soft tissue injuries.
439. Describe the function of the muscular system.
440. Describe the function of the skeletal system.
441. List the major bones or bone groupings of the spinal column; the thorax; the upper extremities; the lower extremities.
442. Differentiate between an open and a closed painful, swollen, deformed extremity.
443. State the reasons for splinting.
444. List the general rules of splinting.
445. List the complications of splinting.
446. List the emergency medical care for a patient with a painful, swollen, deformed extremity.
447. Explain the rationale for splinting at the scene versus load and go.
448. Explain the rationale for immobilization of the painful, swollen, deformed extremity.
449. Demonstrate the emergency medical care of a patient with a painful, swollen, deformed extremity.
450. Demonstrate completing a prehospital care report for patients with musculoskeletal

injuries.
451. State the components of the nervous system.
452. List the functions of the central nervous system.
453. Define the structure of the skeletal system as it relates to the nervous system.
454. Relate mechanism of injury to potential injuries of the head and spine.
455. Describe the implications of not properly caring for potential spine injuries.
456. State the signs and symptoms of a potential spine injury.
457. Describe the method of determining if a responsive patient may have a spine injury.
458. Relate the airway emergency medical care techniques to the patient with a suspected spine injury.
459. Describe how to stabilize the cervical spine.
460. Discuss indications for sizing and using a cervical spine immobilization device.
461. Establish the relationship between airway management and the patient with head and spine injuries.
462. Describe a method for sizing a cervical spine immobilization device.
463. Describe how to log roll a patient with a suspected spine injury.
464. Describe how to secure a patient to a long spine board.
465. List instances when a short spine board should be used.
466. Describe how to immobilize a patient using a short spine board.
467. Describe the indications for the use of rapid extrication.
468. List steps in performing rapid extrication.
469. State the circumstances when a helmet should be left on the patient.
470. Discuss the circumstances when a helmet should be removed.
471. Identify different types of helmets.
472. Describe the unique characteristics of sports helmets.
473. Explain the preferred methods to remove a helmet.
474. Discuss alternative methods for removal of a helmet.
475. Describe how the patient's head is stabilized to remove the helmet.
476. Differentiate how the head is stabilized with a helmet compared to without a helmet.
477. Explain the rationale for immobilization of the entire spine when a cervical spine injury is suspected.
478. Explain the rationale for utilizing immobilization methods apart from the straps on the cots.
479. Explain the rationale for utilizing a short spine immobilization device when moving a patient from the sitting to the supine position.
480. Explain the rationale for utilizing rapid extrication approaches only when they indeed will make the difference between life and death.
481. Defend the reasons for leaving a helmet in place for transport of a patient.
482. Defend the reasons for removal of a helmet prior to transport of a patient.
483. Demonstrate opening the airway in a patient with suspected spinal cord injury.
484. Demonstrate evaluating a responsive patient with a suspected spinal cord injury.
485. Demonstrate stabilization of the cervical spine.
486. Demonstrate the four person log roll for a patient with a suspected spinal cord injury.
487. Demonstrate how to log roll a patient with a suspected spinal cord injury using two

people.

488. Demonstrate securing a patient to a long spine board.
489. Demonstrate using the short board immobilization technique.
490. Demonstrate procedure for rapid extrication.
491. Demonstrate preferred methods for stabilization of a helmet.
492. Demonstrate helmet removal techniques.
493. Demonstrate alternative methods for stabilization of a helmet.
494. Demonstrate completing a prehospital care report for patients with head and spinal injuries.
495. Identify the developmental considerations for the following age groups:
    - infants
    - toddlers
    - pre-school
    - school age
    - adolescent
496. Describe differences in anatomy and physiology of the infant, child and adult patient.
497. Differentiate the response of the ill or injured infant or child (age specific) from that of an adult.
498. Indicate various causes of respiratory emergencies.
499. Differentiate between respiratory distress and respiratory failure.
500. List the steps in the management of foreign body airway obstruction.
501. Summarize emergency medical care strategies for respiratory distress and respiratory failure.
502. Identify the signs and symptoms of shock (hypoperfusion) in the infant and child patient.
503. Describe the methods of determining end organ perfusion in the infant and child patient.
504. State the usual cause of cardiac arrest in infants and children versus adults.
505. List the common causes of seizures in the infant and child patient.
506. Describe the management of seizures in the infant and child patient.
507. Differentiate between the injury patterns in adults, infants, and children.
508. Discuss the field management of the infant and child trauma patient.
509. Summarize the indicators of possible child abuse and neglect.
510. Describe the medical legal responsibilities in suspected child abuse.
511. Recognize need for EMT-Basic debriefing following a difficult infant or child transport.
512. Explain the rationale for having knowledge and skills appropriate for dealing with the infant and child patient.
513. Attend to the feelings of the family when dealing with an ill or injured infant or child.
514. Understand the provider's own response (emotional) to caring for infants or children.
515. Demonstrate the techniques of foreign body airway obstruction removal in the infant.
516. Demonstrate the techniques of foreign body airway obstruction removal in the child.

517. Demonstrate the assessment of the infant and child.
518. Demonstrate bag-valve-mask artificial ventilations for the infant.
519. Demonstrate bag-valve-mask artificial ventilations for the child.
520. Demonstrate oxygen delivery for the infant and child.
521. Discuss the medical and non-medical equipment needed to respond to a call.
522. List the phases of an ambulance call.
523. Describe the general provisions of state laws relating to the operation of the ambulance and privileges in any or all of the following categories:
    - Speed
    - Warning lights
    - Sirens
    - Right-of-way
    - Parking
    - Turning
524. List contributing factors to unsafe driving conditions.
525. Describe the considerations that should by given to:
    - Request for escorts.
    - Following an escort vehicle.
    - Intersections.
526. Discuss "Due Regard For Safety of All Others" while operating an emergency vehicle.
527. State what information is essential in order to respond to a call.
528. Discuss various situations that may affect response to a call.
529. Differentiate between the various methods of moving a patient to the unit based upon injury or illness.
530. Apply the components of the essential patient information in a written report.
531. Summarize the importance of preparing the unit for the next response.
532. Identify what is essential for completion of a call.
533. Distinguish among the terms cleaning, disinfection, high-level disinfection, and sterilization.
534. Describe how to clean or disinfect items following patient care.
535. Explain the rationale for appropriate report of patient information.
536. Explain the rationale for having the unit prepared to respond.
537. Describe the purpose of extrication.
538. Discuss the role of the EMT-Basic in extrication.
539. Identify what equipment for personal safety is required for the EMT-Basic.
540. Define the fundamental components of extrication.
541. State the steps that should be taken to protect the patient during extrication.
542. Evaluate various methods of gaining access to the patient.
543. Distinguish between simple and complex access.
544. Explain the EMT-Basic's role during a call involving hazardous materials.
545. Describe what the EMT-Basic should do if there is reason to believe that there is a hazard at the scene.
546. Describe the actions that an EMT-Basic should take to ensure bystander safety.
547. State the role the EMT-Basic should perform until appropriately trained personnel arrive at the scene of a hazardous materials situation.

548. Break down the steps to approaching a hazardous situation.
549. Discuss the various environmental hazards that affect EMS.
550. Describe the criteria for a multiple-casualty situation.
551. Evaluate the role of the EMT-Basic in the multiple-casualty situation.
552. Summarize the components of basic triage.
553. Define the role of the EMT-Basic in a disaster operation.
554. Describe basic concepts of incident management.
555. Explain the methods for preventing contamination of self, equipment and facilities.
556. Review the local mass casualty incident plan.
557. Given a scenario of a mass casualty incident, perform triage.
558. Identify and describe the airway anatomy in the infant, child and the adult.
559. Differentiate between the airway anatomy in the infant, child, and the adult.
560. Explain the pathophysiology of airway compromise.
561. Describe the proper use of airway adjuncts.
562. Review the use of oxygen therapy in airway management.

Other knowledge and competencies may be added as revisions occur with the National Standard EMT Basic Curriculum.

Note: Skills and medications not listed in these regulations may not be performed by any BLS provider until each skill and/or medication has been individually and specifically approved by DEMS in writing.

7.17. Area and Scope of Practice of the EMT-Basic

The EMT-Basic represents the first component of the emergency medical care system. Through proper training the EMT-Basic will be able to provide basic life support to victims during emergencies, minimize discomfort and possible further injuries. The EMT-Basic may provide non-invasive emergency procedures and services to the level described in the EMT-Basic National Standard Training Curriculum. Those procedures include recognition, assessment, management, transportation and liaison.

An EMT-Basic is a person who has successfully completed an approved training program and is certified. The EMT-Basic training program must equal or exceed the educational goals and objectives of the National Standard Training curriculum for the EMT-Basic.

Policy for Administration

It is appropriate to transport patients whose urgent needs or reasonably perceived needs for care exceed the scope of practice for the ambulance attendant, if the following conditions are present:

a.) The patient has existing advanced therapeutics or treatment modalities for a

preexisting condition, and

b.) The patient is located in a non-hospital setting, and

c.) The patient's condition is considered to be so urgent that the benefits of prompt transport by available personnel to an appropriate hospital outweigh the increased risk to the patient from effecting a delay waiting for qualified medical personnel to arrive.

7.17.1 The person possessing the highest level of certification/license must attend the patient unless otherwise authorized by medical control or as otherwise specified by approved protocols.

7.17.2 EMTs of all levels (Basic, Intermediate, Paramedic), may attend and transport by ambulance, patients who have pre-existing procedures or devices that are beyond the EMT's scope of practice if:

1. there is no need, or reasonably perceived need, for the device or procedure during transport; or

2. an individual (including the patient himself) that has received training and management of the procedure or device accompanies the patient to the destination.

Note: Should doubt exist in regards to the transport of any device or procedure, medical control should be contacted for medical direction.

Section 8

EMT-Advanced Life Support

EMT-Advanced Life Support

Section 8

The Law §41-59-5. §41-59-33. §41-59-35. §41-59-37. §41-60-13.

8.1 Training Authority for EMT-Advanced Life Support

The Mississippi Vocational-Technical Education Division of the Department of Education, with the cooperation of the Governor's Highway Safety Program, the Mississippi State Department of Health, and the American College of Surgeons-Mississippi Committee on Trauma, and the Mississippi Chapter of the American College of Emergency Physicians, offered the advanced life support training course through the Mississippi Community College System. The guidelines and minimum standards are set forth in order to establish a minimum level of training for the Emergency Medical Technician at the Advanced level. These guidelines and minimum standards shall be met by all Advanced Emergency Medical Technician Courses in the state. The University of Mississippi Medical Center, Department of Emergency Medical Technology, is authorized by the DEMS to conduct ALS training programs statewide. All advanced life support programs must have the DEMS approval.

8.2 EMT Advanced Life Support Curriculum

EMT-Paramedic curriculum must conform, at minimum, to the National Standard Training Curriculum developed by the United States Department of Transportation and all current revisions as approved for use by the DEMS. Minimum hours required for EMT-Paramedic are: 1200 didactic/lab, 250 clinical, 250 field. EMT-Intermediate curriculum shall consist of modules numbers I, II, and III as developed for the United States Department of Transportation under Contract No. DOT-HS-900-089, as well as, the DEMS, EMT-Intermediate defibrillation curriculum. Minimum hours required for EMT-Intermediate are: 150 didactic, 40 clinical, 40 field. Written permission from the Director of the DEMS must be obtained prior to the start of an EMT-Intermediate course.

8.3. Request for Approval of EMT Advanced Level Training Programs

Note: A list of DEMS approved EMT Advanced Level training programs will be available at the DEMS office and DEMS web site.

8.3.1. All DEMS approved advanced life support training programs must be accredited by the Committee on Accreditation of Education Programs for the EMS Professions (CoAEMSP). DEMS shall be present for any site visit conducted by the Committee on Accreditation of Education Programs for the EMS Professions (CoAEMSP).

8.3.2. Pre-requisites for beginning a new advanced life support program without the

existence of an accredited paramedic program.

The following requirements are to be met and approved by the DEMS before the approval will be issued to begin the programs instructional component:

a.) Full time program director who's position is delineated by the Standards and Guidelines for an Accredited Educational Program For the Emergency Medical Technician-Paramedic, B.1.a.1. This must be verified by a copy of a contractual agreement to the DEMS.

b.) A Medical Director who's position is delineated by the Standards and Guidelines for an Accredited Educational Program For the Emergency Medical Technician-Paramedic, B.1.a.2. This must be verified by a copy of a contractual agreement to the DEMS.

c.) Instructional Faculty who's qualifications will be delineated by the Standards and Guidelines for an Accredited Educational Program For the Emergency Medical Technician-Paramedic, B.1.b. This must be verified by a copy of a contractual agreement to the DEMS.

d.) Financial Resources will be adequate as described by the Standards and Guidelines for an Accredited Educational Program For the Emergency Medical Technician-Paramedic, B.2. This must be verified by a letter from administration.

e.) Physical Resources as delineated by the Standards and Guidelines for an Accredited Educational Program For the Emergency Medical Technician-Paramedic, B.3.a. and b. This will be verified by a site visit by a staff member of DEMS.

f.) Clinical Resources as delineated by the Standards and Guidelines for an Accredited Educational Program For the Emergency Medical Technician-Paramedic, B.4.and B.5. This must be verified by a copy of a contractual agreement from each site to the DEMS.

Before a consecutive class will be authorized to commence, the Self Study, as specified by Committee on Accreditation of Education Programs for the EMS Professions (CoAEMSP) formerly known as the Joint Review Committee on Educational Programs for the EMT Paramedic (JRCEMT-P), is to be completed and submitted to the CoAEMSP's administrative office with the appropriate fees.

To maintain training authority, the programs must submit:

a.) reports of training activities as specified by DEMS; copies of any and all written communications to and from the school and the Committee on Accreditation of Education Programs for the EMS Professions (CoAEMSP) and/or CAAHEP, will be submitted within (10) ten working days from submitting or receiving to DEMS.

b.) program updates and revisions as specified by DEMS. All reports and updates must be submitted to the DEMS no later than June 30 of each year.

The University of Mississippi Medical Center, Department of Emergency Medical Technology, is authorized by the DEMS to conduct ALS training programs statewide.

8.4. EMT Advanced Training Programs

8.4.1. The length of the EMT-Intermediate course shall not be less than 150 hours didactic, 40 hours of hospital clinical and 40 hours of pre-hospital field clinical. The length of the EMT-Paramedic course shall not be less that 800 hours didactic/lab, 200 hours of hospital clinical and 200 hours of pre-hospital field clinical.

8.4.2. The complete EMT Advanced Level educational programs must be designed to provide the knowledge that will allow the student to arrive at decisions based on accepted medical knowledge and that will permit professional growth.

8.4.3. The program shall consist of, at minimum, three components: didactic instruction, hospital clinical lab and practical evaluation in pre-hospital field clinicals under a medical command authority. The time required to complete each component may vary, in part being dependent on the ability of students to demonstrate their mastery of the educational objectives by written, verbal, and practical examination.

8.4.4. The program shall maintain on file, for each component of the curriculum, a reasonable comprehensive list of the terminal performance objectives to be achieved by the student. These objectives must delineate mastery in all competencies identified, including curriculum documentation, measurement techniques used, and the records maintained on each student's work.

8.4.5 The student must be informed about the methods and data used in determining grades and about the mechanism for appeal. Conditions governing dismissal from the program should be clearly defined in writing and distributed to the student at the beginning of the training program.

8.4.6 Evidence of student competence in achieving the educational objectives of the program must be kept on file. Documentation must be in the form of both written and practical examinations.

8.4.7. Classroom, clinical and field faculty must also prepare written evaluations on each student. Documentation must be maintained identifying the counseling given to individual students regarding their performance and the recommendations maintained identifying the counseling given to individual students regarding their performance and the recommendations made to correct inadequate performance. Documentation on whether or not the student followed through on faculty recommendations should also be maintained. Instruction should be supported by performance assessments.

8.4.8. Faculty must be presented with the program's educational objectives for uses in preparation of lectures and field practicals. The course coordinator must ensure that stated educational objectives are covered and should answer any questions from students or clarify information presented by a lecturer.

a. Didactic instruction:
Lectures, discussions, and demonstrations presented by physicians and others who are competent in the field.

b. Clinical and Other Settings:
Instruction and supervised practice of emergency medical skills. Practice should not be limited to the development of practical skills alone, but should include knowledge and techniques regarding patient evaluations, development of patient rapport, and care for and understanding of the patient's illness. Documentation must be maintained for each students performance in all of the various areas. A frequent performance evaluation is recommended.

c. A Field Experience:
The field internship is a period of supervised experience in a structured overall EMS system. It provides the student with a progression of increasing patient care responsibilities which proceed from observation to working as a member of a team. There must be a provision for physician evaluation of student progress in acquiring the desired skills to be developed through this experience. The EMT Advanced Level student must have telecommunication with medical command authority. The initial position of the student on the EMS care team should be that of observer only utilizing limited learned skills. After progression through record keeping and participation in actual patient care, the student must eventually function as the patient care leader. However, the student must not be placed in the position of being a necessary part of the patient care team. The team must be able to function without the necessary use of a student who may be present.

8.4.9. General courses and topics of study must be achievement oriented and shall provide students with:

a. The ability to recognize the nature and seriousness of the patients condition or extent of injuries to access requirements for emergency medical care;

b. The ability to administer appropriate emergency medical care based on assessment findings of the patients condition;

c. Lift, move, position and otherwise handle the patient to minimize discomfort and prevent further injury; and,

d. Perform safely and effectively the expectations of the job description.

Other Information:

Operational Policies

Student matriculation practices and student and faculty recruitment should be non-discriminatory with respect to race, color, creed, sex or national origin. Student matriculation and student and faculty recruitment practices are to be consistent with all laws regarding non-discrimination. It is recommended that records be kept for a reasonable period of time on the number of students who apply and the number who successfully complete training.

a.) Announcements and advertising about the program shall reflect accurately the training being offered.
b.) The program shall be educational and students shall use their schedule time for educational experiences.
c.) Health and safety for students, faculty, and patients shall be adequately safeguarded.
d.) Cost to the student shall be reasonable and accurately stated and published.
e.) Policies and process for student withdrawal and refunds on tuition on fees shall be fair, and made known to all applicants.

Curriculum Description - EMT-Intermediate

Instructional content of the educational program should include the successful completion of stated educational objectives that fulfill local and regional needs and that satisfy the requirements of this curriculum section. The curriculum should be organized to provide the student with knowledge required to understand fully the advanced skills that are taught in this program. It is important not to loose sight of the original purpose of the EMT Intermediate level. The curriculum includes only the portions of the NSTC for the EMT Paramedic which are relevant for this level of care. Students should have an opportunity to acquire clinical experience and practical skills related to the emergency medical care of these patients. Students should also understand the ethical and legal responsibilities they assume as students are being prepared to assume as graduates.

a.) MS EMT-I training shall also include the instructor lesson plan for EMT-I National Standard Training Curriculum (NSTC), Defibrillation Section. Additionally, it should be noted that current AHA Standards and Guidelines for CPR and ECC will supersede NSTC.
b.) The length of the EMT-I defibrillation course shall not be less than 16 hours (12 hours didactic and 4 hours practical).
c.) The educational program should be designed to provide the knowledge that will allow the student to arrive at decisions based on accepted medical knowledge and that will permit the professional growth of the EMT-Intermediate.
d.) The program should consist of three components: didactic instruction, clinical instruction, and supervised field experience in an advanced life support unit which functions under a medical command authority. The time required to complete each component may vary, in part being dependent upon the ability of students to demonstrate their mastery of the educational objectives by written, verbal, and practical examination.
e.) The program should maintain on file for each component of the curriculum a reasonable comprehensive list of the terminal performance objectives to be achieved by the student. These objectives should delineate mastery in all competencies identified, including curriculum documentation, measurement techniques used, and the records maintained on each student's work.
f.) The student should be informed about the methods and data used in determining grades and about the mechanism for appeal. Conditions governing dismissal from the program should be clearly defined in writing and distributed to the student at the beginning of the training program.

g.) Evidence of student competence in achieving the educational objectives of the program should be kept on file. Documentation should be in the form of both written and practical examinations.

h.) Classroom, clinical, and field faculty should also prepare written evaluations on each student. Documentation should be maintained identifying the counseling given to individual students regarding their performance and the recommendations made to correct inadequate performance. Documentation on whether or not the student followed through on faculty recommendations should also be maintained. Instruction should be supported by performance assessments.

i.) Faculty should be presented with the program's educational objectives for uses in preparation of lectures and clinical and field practice. The course coordinator should ensure that stated educational objectives are covered and should answer any questions from students or clarify information presented by a lecturer.

a. Didactic instruction:
Lectures, discussions, and demonstrations presented by physicians and others who are competent in the field.

b. Clinical (in-hospital) and other settings:
Instruction and supervised practice of emergency medical skills in critical care units, emergency departments, operating rooms and other settings as appropriate. Supervision in the hospital can be provided either by hospital personnel, such as supervisory nurses, department supervisors, and physicians, or by the program instructor. The hospital practice should not be limited to the development of practical skills alone, but should include knowledge and techniques regarding patient evaluations, pathophysiology of medical and surgical conditions, development of patient rapport, and care for and understanding of the patient's illness. Documentation should be maintained for each student's performance in all of the various areas. A frequent performance evaluation is recommended.

c. Field Experience:
The field internship is a period of supervised experience on an intensive care vehicle. It provides the student with a progression of increasing patient care responsibilities which proceed from observation to working as a member of a team. There should be a provision for physician evaluation of student progress in acquiring the desired skills to be developed through this experience. The intensive care vehicle should have telecommunication with medical command authority. The student must be under the direct supervision and observation of a physician, or nurse with experience in the pre-hospital ALS setting, or an EMT-Paramedic approved by the medical command authority. The experience should occur within an emergency medical care system that involves EMT-Paramedics in the provision of advanced emergency medical services and that maintains a defined program of continuing education for its personnel. The initial position of the student on the pre-hospital care team should be that of observer. After progressing through record keeping and participation in actual patient care, the student should eventually function as the patient care leader. However, the student should not be placed in the position of being a necessary part of the patient care team. The team should be able to function without the necessary use of a student who may be present. The ALS Provider being utilized should have established a continuing education program for its field personnel that adequately maintains an acceptable level of

required skills and knowledge. The ALS Provider should function under communications with a medical control authority that provides pre-hospital direction of the patient care. The ALS Provider should also have a program to provide prompt review of pre-hospital care provided by the EMT-Intermediate.

j.) General courses and topics of study must be achievement oriented and shall provide students with:

a. The necessary knowledge, skills, and attitudes to perform accurately and reliably the functions and tasks stated and implied in the "Description of the Occupation" found in the DOT, NSTC Course Guide.

b. Comprehensive instruction which encompasses:

(i) Orientation to the occupation

(a) Responsibilities of the role
(b) Inter-professional responsibilities
(c) Career pathways in emergency medical services

(ii) Development of interpersonal skills

(a) Awareness of one's abilities and limitations
(b) Ability to accept direction
(c) Awareness of impact to others
(d) Willingness and ability to communicate with others
(e) Ability to build a working relationship with patients and peers
(f) Ability to function as a team member and/or team leader
(g) Ability to accept patients as they present themselves, without passing judgements
(h) Ability to involve others significant to the patient
(i) Ability to respond to a patient's sense of crisis

(iii) Development of knowledge and clinical skills appropriate for this level of care

(a) Roles and responsibilities of the EMT-Intermediate
(b) Emergency medical services systems and medical control
(c) Medical/legal consideration
(d) Communication procedures
(e) Medical terminology
(f) Patient assessment including both a primary and secondary survey
(g) Airway management procedures
(h) Assessment and management of shock

NOTE: The following curriculum must be taught in addition to that listed above.

k.) EMT-I - Curriculum For Defibrillation

Introduction: The student must have successfully completed the following sections prior to participating in this section:

Section 1. Roles and Responsibilities
Section 2. EMS Systems
Section 3. Medical/Legal Considerations
Section 4. Medical Terminology

Section 5. EMS Communications
Section 6. General Patient Assessment and Initial Management

l.) Because of the high number of pre-hospital deaths attributed to coronary artery disease, this is a subject that continues to receive great emphasis in the training of the EMT-I. This is particularly true in light of recent data which suggests that early defibrillation makes a significant difference in the outcome of patients suffering from ventricular fibrillation.

Overview

I. Anatomy and Physiology of the Cardiovascular System
   A. Anatomy of the Heart
   B. Physiology of the Heart
   C. Electrophysiology (Basics)
II. Assessment of the Cardiac Patient
   A. Common Chief Complaints and History
   B. Significant Past Medical History
   C. Physical Examination Pertinent to the Cardiac Patient
III. Pathophysiology and Management
   A. Pathophysiology of Atherosclerosis
   B. Specific Conditions Resulting from Atherosclerosis Heart Disease
      1. Angina Pectoris
      2. Acute Myocardial Infarction
      3. Cardiac Arrest/Sudden Death
IV. Dysrhythmia Recognition
   A. Introduction to ECG Monitoring
   B. Rhythm Strip Analysis
   C. Introduction to Dysrhythmias
   D. Dysrhythmias Originating in the Ventricles
V. Techniques of Management
   A. CPR
   B. ECG Monitoring
   C. Defibrillation

Objectives

At the completion of this section the student will be able to:

1. Describe the size, shape, and location/orientation (in regard to other body structures) of the heart muscle.
2. Identify the location of the following structures on a diagram of the normal heart:
   .. Pericardium
   .. Myocardium
   .. Epicardium
   .. Right and left atria
   .. Interatrial Septum
   .. Right and left ventricles
   .. Interventricular septum
   .. Superior and inferior vena cava
   .. Aorta
   .. Pulmonary vessels

.. Coronary arteries
.. Tricuspid valve
.. Mitral valve
.. Aortic valve
.. Pulmonic valve
.. Papillary muscles
.. Chordae Tendineae

3. Describe the function of each structure listed in Objective #2.
4. Describe the distribution of the coronary arteries and the parts of the heart supplied by each artery.
5. Differentiate the structural and functional aspects of arterial and venous blood vessels.
6. Define the following terms that refer to cardiac physiology:
   .. Stroke volume
   .. Starling's Law
   .. Preload
   .. Afterload
   .. Cardiac output
   .. Blood pressure
7. Describe the electrical properties of the heart.
8. Describe the normal sequence of electrical conduction through the heart and state the purpose of this conduction system.
9. Describe the location and function of the following structures of the electrical conduction system:
   .. SA node
   .. Internodal and Interatrial tracts
   .. AV node
   .. Bundle of His
   .. Bundle branches
   .. Purkinje fibers
10. Define cardiac depolarization and repolarization and describe the major electrolyte changes that occur in each process.
11. Describe an ECG
12. Define the following terms as they relate to the electrical activity of the heart:
   .. Isoelectric line
   .. QRS complex
   .. P wave
13. Name the common chief complaints of cardiac patients.
14. Describe why the following occur in patients with cardiac problems:
   .. Chest pain or discomfort
   .. Shoulder, arm, neck, or jaw pain/discomfort
   .. Dyspnea
   .. Syncope
   .. Palpitations/abnormal heart beat
15. Describe those questions to be asked during history taking for each of the common cardiac chief complaints.
16. Describe the four most pertinent aspects of the past medical history in a patient

with a suspected cardiac problem.

17. Describe those aspects of the physical examination that should be given special attention in the patient with suspected cardiac problems.
18. Describe the significance of the following physical exam findings in a cardiac patient:
    .. Altered level of consciousness
    .. Peripheal edema
    .. Cyanosis
    .. Poor capillary refill
    .. Cool, clammy skin
19. State the numerical values assigned to each small and large box on the ECG graph paper for each axis.
20. Define ECG artifact and name the causes.
21. State the steps in the analysis format of ECG rhythm strips.
22. Describe two common methods for calculating heart rate on an ECG rhythm strip and the indications for using each method.
23. Name 8 causes of dysrhythmias.
24. Describe proper use of the following devices used for defibrillation:
    1. manual monitor/defibrillator
    2. semi-automatic monitor/defibrillator
    3. automatic monitor/defibrillator or Automatic defibrillator
25. Demonstrate on an adult mannequin, the technique for single and two-person CPR according to American Heart Association standards.
26. Demonstrate on an infant mannequin, the technique for infant CPR according to American Heart Association standards.
27. Demonstrate proper application of ECG chest electrodes and obtain a sample Lead II.
28. Demonstrate the proper use of the defibrillator paddles electrodes to obtain a sample Lead II rhythm strip.
29. Demonstrate how to properly assess the cause of poor ECG tracing.
30. Demonstrate correct operation of a monitor-defibrillator to perform manual defibrillation on an adult and infant.
31. Correctly identifies and treats within the scope of their practice the following dysrhythmias:
    a. asystole
    b. v-fib
    c. pulseless v-tach
    d. normal sinus rhythm
    e. EMD
    f. artifact
    g. PVC recognition

Curriculum Description - EMT-Paramedic

a.) Instructional content of the educational program shall include the successful completion of stated educational objectives that fulfill local and regional needs and that satisfy the requirements of this curriculum section. The curriculum shall be organized to provide the

student with knowledge of the acute, critical changes in physiology, and in psychological, and clinical symptoms as they pertain to the pre-hospital emergency medical care of the infant, child, adolescent, adult, and geriatric patient. Students shall have an opportunity to acquire clinical experience and practice skills related to the emergency medical care of these patients. Students shall also understand the ethical and legal responsibilities which they assume as students and which they are being prepared to assume as graduates.

The educational program shall be designed to provide the knowledge that will allow the student to arrive at decisions based on accepted medical knowledge and that will permit the professional growth of the EMT-Paramedic.

The program shall consist of three components: didactic instruction, clinical instruction, and supervised field internship in an advanced life support unit that functions under a medical command authority. The time required to complete each component may vary, in part being dependent upon the ability of students to demonstrate their mastery of the educational objectives by written, verbal, and practical examination.

The program shall maintain on file for each component of the curriculum a reasonably comprehensive list of the terminal performance objectives to be achieved by the student. These objectives shall delineate mastery in all competencies identified, including curriculum documentation, measurement techniques used, and the records maintained on each student's work.

The student shall be informed about the methods and data used in determining grades, about pass/fail criteria, and about the mechanism for appeal. Conditions governing dismissal from the program shall be clearly defined in writing and distributed to the student at the beginning of the training program.

Evidence of student competence in achieving the educational objectives of the program shall be kept on file. Documentation shall be in the form of both written and practical examinations.

Classroom, clinical, and field faculty shall also prepare written evaluations on each student. Documentation shall be maintained identifying the counseling given to individual students regarding their performance and the recommendations made to correct inadequate performance. Documentation identifying whether or not the student followed through on faculty recommendations shall also be maintained.

b.) Instruction shall be supported by performance assessments. Faculty shall be presented with the program's educational objectives for use in preparation of lectures and clinical and field practice. The course coordinator shall insure that stated educational objectives are covered and shall answer any questions from students or clarify information presented by a lecturer.

1.) Didactic instruction -
Lectures, discussion, and demonstrations presented by physicians and others who are competent in the field.

2.) Clinical (in-hospital) and other settings -

Instruction and supervised practice of emergency medical skills in critical care units, emergency departments, OB units, operating rooms, psychological crisis intervention centers, and other settings as appropriate.

Supervision in the hospital can be provided either by qualified hospital personnel, such as supervisory nurses, department supervisors and physicians, or by paramedic or nurse program instructors. The hospital practice shall not be limited to the development of practical skills alone, but shall include knowledge and techniques regarding patient evaluations, pathophysiology of medical and surgical conditions, development of patient rapport, and care for and understanding of the patient's illness.

Documentation shall be maintained for each student's performance in all of the various areas. A frequent performance evaluation is recommended.

3.) Field Internship -

"The field internship is a period of supervised experience on an intensive care vehicle which provides the student with a progression of increasing patient care responsibilities which proceeds from observation to working as a team member. There shall be a provision for physician evaluation of student progress in acquiring the desired skills to be developed through this experience."

The intensive care vehicle shall have communication with medical command authority and equipment and drugs necessary for advanced life support. The student must be under the direct supervision and observation of a physician or nurse with experience in the pre-hospital ALS setting, or an EMT-Paramedic approved by the medical command authority.

The experience shall occur within an emergency medical care system that involves EMT-Paramedics in the provision of advanced emergency medical services and that maintains a defined program of continuing education for its personnel.

"The initial position of the student on the pre-hospital care team shall be that of observer. After progressing through record keeping and participation in actual patient care, the student shall ultimately function as the patient care leader. However, the student shall not be placed in the position of being a necessary part of the patient care team. The team should be able to function without the necessary use of a student who may be present."

The ALS Provider being used shall have established a continuing education program for its field personnel that adequately maintains an acceptable level of required skills and knowledge.

The ALS Provider shall function under direct communications with a medical control authority that provides pre-hospital direction of the patient care.

The ALS Provider shall also have a program to provide prompt review of pre-hospital care provided by the EMT-Paramedic.

c.) General courses and topics of study must be achievement oriented and shall provide students with:

1.) The necessary knowledge, skills, and attitudes to perform accurately and reliably the functions and tasks stated and implied in the "Description of the Occupation" found in the DOT, NSTC Course Guide.

2.) Comprehensive instruction which encompasses:

(i) Orientation to the occupation

(a) Responsibilities of the occupation

(b) Professional responsibilities
(c) Career pathways in emergency medical services
(d) Legal responsibilities

(ii) Development of interpersonal skills
(a) Awareness of one's abilities and limitations
(b) Ability to accept direction
(c) Awareness of impact on others
(d) Willingness and ability to communicate with others
(e) Ability to build a working relationship with patients and peers
(f) Ability to function as a team member and/or team leader
(g) Ability to accept patients as they present themselves, without passing judgement
(h) Ability to involve others significant to the patient
(i) Ability to respond to a patient's sense of crisis

(iii) Development of clinical assessment skills
(a) Ability to obtain information rapidly by talking with the patient and by physical examination; by interviewing others; and from observation of the environment
(b) Ability to organize and interpret data rapidly
(c) Ability to communicate concisely and accurately
(d) Ability to understand pertinent anatomy, physiology, pharmacology, microbiology, and psychology

(iv) Development of clinical management and technical skills (from American Medical Association Joint Review Committee Essential Guidelines for EMT-Paramedic Training Programs) relating to the assessment and emergency treatment of:
(a) Medical Emergencies including:
Respiratory System (as addressed in didactic objectives), Cardiovascular system (as addressed in didactic objectives), Endocrine system (as addressed in didactic objectives), Nervous system (as addressed in didactic objectives), Gastrointestinal system (as addressed in didactic objectives), Toxicology (as addressed in didactic objectives), Infectious diseases (as addressed in didactic objectives), Environmental problems (as addressed in didactic objectives), Problems by age extremes i.e., pediatrics, neonatal, geriatrics (as addressed in didactic objectives), Shock (as addressed in didactic objectives), Central nervous system (as addressed in didactic objectives).
(b) Traumatic Emergencies including:
Central nervous system (as addressed in didactic objectives), Neck (as addressed in didactic objectives), Thorax (as addressed in didactic objectives), Abdomen (as addressed in didactic objectives), Extremities (as addressed in didactic objectives), Skin (as addressed in didactic objectives), Environmental (as addressed in didactic objectives), Shock (as addressed in didactic objectives)
(c) Obstetrical/Gynecological Emergencies (as addressed in didactic objectives),
(d) Behavioral Emergencies (as addressed in didactic objectives)
(e) Stress (as addressed in didactic objectives)

(f) Psychiatric disease (as addressed in didactic objectives)
(g) Emotional dysfunction (as addressed in didactic objectives)
(h) Medical personnel communications (as addressed in didactic objectives)
(i) Clinical/Medical equipment (as addressed in didactic objectives and by institution or service policy).

(v.) Development of technical skills:
associated with biomedical communications, including telemetry, record keeping, use of equipment, emergency and defensive driving, and principles and techniques of extrication.

d.) Optional skills shall be included in all EMT-Paramedic training programs.

8.5 EMT Advanced Level classes, class approved

EMT Advanced Level class approval forms can be requested from the DEMS or be completed on the DEMS website. Credentialed EMT Advanced Level instructors should complete the class approval form and submit to the DEMS, at minimum, fourteen calendar days prior to the first day of class. The DEMS will assign a class number to all approved requests and return to the credentialed EMT Advanced Level instructor. Incomplete paperwork will be returned without action.

8.6 EMT Advanced Level classes, initial roster

Initial rosters shall be completed by the credentialed EMT Advanced Level instructor immediately following the second meeting of the class. Initial roster forms can be obtained from the DEMS or be completed on the DEMS website. A final roster for full or refresher EMT Advanced Level class will not be accepted without an initial roster on file with the DEMS.

8.7 EMT Advanced Level classes, final roster

Final rosters shall be completed by the credentialed EMT Advanced Level instructor immediately following the end of a full EMT Advanced Level or EMT Intermediate or Paramedic Refresher class. The final roster shall be inclusive of all students on the initial roster. The final roster will note students who withdrew, failed, and completed the EMT Advanced Level class. The final roster form can be obtained from the DEMS or be completed on the DEMS web site. Students successfully completing the class will not be allowed to test National Registry until a final roster is on file with the DEMS.

8.8 EMT Advanced Level Training Programs, minimum admittance criteria

8.8.1. Must be a Mississippi certified EMT-Basic
8.8.2. Must successfully pass a re-test of EMT-Basic skills and knowledge.
8.8.3. Must provide past academic records for review by an admissions committee (may or may not be faculty members).
8.8.4 Completion of 8 semester hours of human anatomy and physiology (A&P 1 and II with labs) from an accredited post-secondary school. Minimum average of C or higher must be obtained. Human anatomy and physiology may be taken as prerequisite or corequisite

courses.

8.9 EMT Advanced Level Refresher Training

8.9.1. EMT Intermediate Refresher training shall consist of: Successful competition of the EMT-Basic refresher course as outlined previously and successful competition of a formal 14 hour DOT EMT Intermediate refresher training program (must include 2 hours of defibrillation refresher training). Successful competition of Division 1 and 2 of the EMT Paramedic Curriculum will satisfy this requirement.

8.9.2. EMT Paramedic Refresher Block training shall consist of: Successful competition of a formal MSDH, DEMS DOT EMT Paramedic Refresher Training Program. An ACLS course is applicable toward this section within the appropriate blocks and competition of the appropriate terminal competencies.

Note: All EMT-Paramedics trained under the EMT-Paramedic curriculum prior to 1999 must complete a MSDH, DEMS approved 72 hour transitional course.

8.10. Prerequisites to certification as an EMT Advanced Level (training obtained in Mississippi).

8.10.1. Age of at least 18 years.

8.10.2. Completion of the Board's approved Emergency Medical Technician Intermediate or Paramedic Training Program (Note: This includes passage of the National Registry EMT-I or EMT-P examination).

8.10.3. Competition of a DEMS approved EMT-I defibrillation course and passage of the state defibrillation exam (applicable to EMT-Intermediate only), or equivalent with MSDH, DEMS approved terminal competencies (ACLS may be substituted for the EMT-I defibrillation course, but applicant must still pass the state defibrillation exam.)

8.10.4. Must meet all Mississippi criteria for EMT Basic certification.

8.10.5. Verification of medical control (Jurisdictional Medical Control Agreement)

Note: All EMT-Paramedics trained under the EMT-Paramedic curriculum prior to 1999 must complete a MSDH, DEMS approved 72 hour transitional course.

8.11. Prerequisites to certification as an EMT-Advanced (training obtained in another state)

8.11.1. Age of at least 18 years.

8.11.2. An applicant must demonstrate a need for reciprocity by submitting a Jurisdictional Medical Control Agreement from a licensed ambulance service or a facility providing Advanced life support service indicating the applicant is presently employed or will be employed upon moving to the state.

8.11.3. Completion of an EMT-Intermediate or EMT-Paramedic program (Advanced level), which meets the guidelines of the national standard curriculum for EMT-I or EMT-P. A copy of the program curriculum and educational objectives must be submitted to and approved by the DEMS.

8.11.4. Applicant must be registered as an EMT-Intermediate or EMT-Paramedic by the

National Registry of EMTs. This is documented by submitting a copy of the National Registry wallet card to the DEMS. Must meet all Mississippi criteria for EMT-B certification.

Note: All EMT-Paramedics trained under the EMT-Paramedic curriculum prior to 1999 must complete a MSDH, DEMS approved 72 hour transitional course.

Note: The Mississippi DEMS maintains the right to refuse reciprocity to any EMT-Intermediate and EMT-Paramedic if the submitted curriculum does not meet the guidelines of the national standard curriculum and those required by the state of Mississippi.

8.12. EMT-Advanced Certification

8.12.1. Any person desiring certification as an EMT-Advanced shall apply to DEMS using forms provided (Application for state certification)

8.12.2. All certification applications must be accompanied by EMT-Intermediate twenty dollar ($20.00), or EMT-Paramedic twenty-five dollars ($25.00) money order payable to the Mississippi State Department of Health. Also include copy of current National Registry card and a Jurisdictional Medical Control Agreement.

8.12.3 The DEMS may withhold or deny an application for certification for a like period of time equal to the period of time under which a person failed to comply. Mississippi requires that all EMT-I/P maintain current registration with the National Registry of Emergency Medical Technicians.

8.13. EMT-Advanced Level Re-certification

8.13.1. Any person desiring re-certification as an EMT- I/P shall apply to DEMS using forms provided (Application for state certification)

8.13.2. All re-certification applications must be accompanied by EMT-Intermediate twenty dollar ($20.00), or EMT-Paramedic twenty-five dollar ($25.00) money order payable to the Mississippi State Department of Health. Also include copy of current National Registry card equivalent to the level of re-certification requested and a Jurisdictional Medical Control Agreement (JMCA). (Jurisdictional Medical Control Agreements are valid only for the certification period in which they are submitted. Therefore, all EMT-Intermediates and EMT-Paramedics recertifying must complete and resubmit a JMCA for each licensed provider for which they function.)

8.13.3. All EMT's failing to re-certify with DEMS on or before the expiration date of his/her certification period will be considered officially expired.

8.13.4. DEMS may withhold or deny an application for re-certification for a like period of time equal to the like period of time under which a person fails to comply.

Note: All EMT-Paramedics trained under the EMT-Paramedic curriculum prior to 1999 must complete a MSDH, DEMS approved 72 hour transitional course.

Note: All EMT-Paramedics trained prior to 1991 or trained in another state must provide

evidence of training in all optional skills identified by the DEMS. This training must be obtained through a state approved training program.

8.14. EMT Advanced Level, Grounds for Suspension or Revocation.
The DEMS may suspend or revoke a certificate so issued at any time it is determined that the holder no longer meets the prescribed qualifications.

8.14.1. Fraud or any mis-statement of fact in the procurement of any certifications or in any other statement of representation to the Board or its representatives.
8.14.2. Gross negligence.
8.14.3. Repeated negligent acts.
8.14.4. Incompetence.
8.14.5. Disturbing the peace while on duty
8.14.6. Disregarding the speed regulations prescribed by law while on duty.
8.14.7. Failure to carry the DEMS issued certification card while on duty or failure to wear appropriate identification as approved by the DEMS.
8.14.8. Failure to maintain current registration by the National Registry of EMTs.
8.14.9. Failure to maintain all current EMT-Advanced training standards as required by the DEMS.
8.14.10. The commission of any fraudulent dishonest, or corrupt act which is substantially related to the qualifications, functions, and duties of pre-hospital personnel.
8.14.11. Conviction of any crime which is substantially related to the qualification, functions, and duties of pre-hospital personnel. The record of conviction or certified copy thereof will be conclusive evidence of such conviction.
8.14.12. Violating or attempting to violate directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this part of the regulations promulgated by the DEMS, pertaining to pre-hospital personnel.
8.14.13. Violating or attempting to violate any federal or state statute or regulation which regulates narcotics, dangerous drugs, or controlled substances.
8.14.14. Addiction to, excessive use of, or misuse of, alcoholic beverages, narcotics, dangerous drugs, or controlled substances.
8.14.15. Functioning outside the supervision of medical control in the field care system operating at the local level, except as authorized by certification and license issued to the ALS provider.
8.14.16. Permitting, aiding or abetting an unlicenced or uncertified person to perform activities requiring a license or certification.
8.14.17. Suspension or revocation of any DEMS issued certification may effect other DEMS issued certifications at all levels.

8.15. Description of the Occupation and Competency of the EMT-Advanced

"The Emergency Medical Technician-Intermediate or Emergency Medical Technician-Paramedic (EMT-I/P) is qualified in advanced emergency care and services by a competency-based training program of clinical, didactic, and practice instruction and by a field internship. Competencies include but are not limited to the recognition, assessment, and management of medical emergencies under the direction of a physician."

"An EMT-I is a person who has successfully completed both a EMT-B and an EMT-I training program curriculum that shall consist of modules numbers I, II, III as developed for the United State Department of Transportation under Contract No. DOT-HS-900-089 as well as the MSDH, DEMS EMT-Intermediate defibrillation curriculum and is certified or licensed.

An EMT-P is a person who has successfully completed both a EMT-B and an EMT-P training program and is certified. The EMT-I or EMT-P training programs are programs of instruction which equal or exceed the educational goals and objectives of the National Standard Emergency Medical Technician - Intermediate or Paramedic Course."

"Competency, knowledge, awareness of one's abilities and limitations, the ability to relate with people, and a capacity for calm and reasoned judgment while under stress are essential attributes of the EMT-I and EMT-P. The EMT-I and EMT-P respects the individuality and privacy of patients and their family members."

8.15.1. Competency of the EMT-Intermediate

Given the knowledge, skills, and field experience, the EMT-I is competent in:

A. Recognizing a medical emergency; assessing the situation managing emergency care and, if needed, extrication; coordinating his efforts with those of other agencies involved in the care and transportation of the patient; and establishing rapport with the patient and significant others to decrease their state of crisis.
B. Assigning priorities of the emergency treatment and recording and communicating data to the designated medical command authority.
C. Initiating and continuing emergency medical care under medical control including the recognition of presenting conditions and initiation of appropriate invasive and non-invasive therapy.
D. Exercising personal judgment in case of interruption in medical direction caused by communication failure or in case of immediate life-threatening conditions. (Under these circumstances, provides such emergency care as has been specifically authorized in advance.)

8.15.2. Competency of the EMT-Paramedic

Given the knowledge, skills, and field experience, the EMT-P is competent in:

A. Recognizing a medical emergency; assessing the situation; managing emergency care and, if needed, extrication; coordinating his efforts with those of other agencies involved in the care and transportation of the patient; and establishing rapport with the patient and significant others to decrease their state of crisis.
B. Assigning priorities of emergency treatment and recording and communicating data to the designated medical command authority.
C. Initiating and continuing emergency medical care under medical control, including the recognition of presenting conditions and initiation of appropriate invasive and noninvasive therapies (e.g., surgical and medical

emergencies, airway and respiratory problems, cardiac dysrhythmias, cardiac pulmonary arrest, and psychological crises), and assessing the response of the patient to that therapy.

D. Exercising personal judgment in case of interruption in medical direction caused by communications failure or in cases of immediate life-threatening conditions. (Under these circumstances, the EMT-P provides such emergency care as has been specifically authorized in advance.)

8.16. Performance Standards for Emergency Medical Technician-Advanced Levels.

The EMT-Intermediate and EMT-Paramedic who functions within the State of Mississippi, must be able to demonstrate the following skills to the satisfaction of the EMS medical director and the DEMS, State Department of Health, to meet criterion established for advanced life support personnel.

The skills listed herein are in addition to those performed by the EMT-Basic. Some of the skills are restricted to performance by EMT-Paramedics. Others may be performed by EMT-Intermediates as well.

Skills preceded by an asterisk (*) indicate those restricted to EMT-P's. No markings indicate that the skill may be performed by both levels of ALS personnel.

It should be noted that utilization of some of the more specialized advanced skills require special approval by the medical director each time they are attempted.

A. Perform an appropriate patient assessment, including: history taking a chief complaint, pertinent history of the present illness and past medical history). Physical examination, including: assessment of vital signs, including pulse, blood pressure, and respirations. Trauma-oriented and medically oriented head-to-toe surveys, including, but not limited to:
   1. inspection and palpation of the head and neck;
   2. inspection of the chest and auscultation of heart and lung sounds
   3. inspection of the abdomen and auscultation of abdominal sounds;
   4. inspection and palpation of extremities;
   5. evaluation of neurological status and neuromuscular function.

B. Demonstrate aseptic technique of extremity peripheral venipuncture and drawing blood samples for hospital use only and Blood Glucose Determination by capillary sample (Limited to Unconscious Patients only for EMT-Intermediate).

*C. Demonstrates aseptic technique of external jugular intravenous insertion in life threatening situations when alternate sites are impractical. Demonstrate techniques of maintenance of central intravenous therapy (internal jugular, subclavian, femoral) EMT-P's are limited to only monitoring central line IV's; they shall not initiate central lines. The central line IV's may be used for approved fluid and drug administration only. Hemodynamic monitoring shall not be performed by EMT-P's.

NOTE: EMT-Intermediates and EMT-Paramedics are permitted to monitor and administer only those IV fluids and/or medications which are approved by the DEMS and listed in these

performance standards.

D. Demonstrates the techniques for aseptic assembly of intravenous equipment and for calculation of flow rates.

E. Demonstrate the techniques of establishing an IV infusion using a catheter-over-the-needle device.

F. Recall and demonstrate use of the type of IV fluid appropriate in:
   1. a "keep open" lifeline in cardiac patients
   2. hypovolemic shock
   3. specific medical emergencies

(EMT-Intermediates do not routinely start IV's on patients in categories 1 and 3. Their training concentrates on trauma and hypovolemic patients. They may, however, be requested to establish IV's in other situations such as when they are awaiting the arrival of higher qualified ALS personnel).

G. The following IV fluids are approved by the DEMS for Advanced Life Support Levels.

EMT-Intermediate
Normal Saline, Lactated Ringers and Dextrose 5% fluids may be initiated or transported in accordance with a DEMS approved medical control plan.

EMT-Paramedic
Isotonic, hypotonic and hypertonic solutions may be initiated on a patient and transported, in accordance with a DEMS approved medical control plan.

H. Demonstrate the application, inflation, and correct sequence of deflation of the pneumatic anti-shock garment (PASG).

*I. Demonstrate the technique for calculating dosage and drawing up a designated volume of medication in a syringe from an ampule or vial.

*J. Demonstrate the technique for administering drugs using a prepackaged disposable syringe.

*K. Demonstrate technique of subcutaneous, intradermal, intramuscular, intravenous, and intra tracheal administration of drugs.

*L. List of indications, contraindications, actions, dosage, and route of administration of each of the following drugs:
   (1) Activated Charcoal
   (2) Adenosine
   (3) Antiemetics
   (4) Aspirin
   (5) Atropine
   (6) Bretylium
   (7) Bronchodialators
   (8) Calcium Chloride
   (9) Cetacaine
   (10) Demerol
   (11) Dexamethasone
   (12) Dextrose 50%

(13) Diastat ~~(only form of rectally administered diazapam allowable)~~
(14) Diazepam
(15) Diphenhydramine
(16) Dobutamine
(17) Epinephrine
(18) Flumazenil
(19) Furosemide
(20) Glucagon
(21) Glyco-Protein Inhibitors*
(22) Haldol
(23) Heparin*
(24) Isoproterenol
(25) Lidocaine
(26) Lorazepam
(27) Magnesium Sulfate
(28) Mannitol
(29) Morphine
(30) Naloxone
(31) Nitroglycerine (spray or tablets)
(32) Nitroglycerine Infusion*
(33) Nitrous Oxide
(34) Oxytocin
(35) Pralidoxime (2-PAM)
(36) Potassium chloride*
(37) Procainamide
(38) Sodium Bicarbonate
(39) Syrup of Ipecac
(40) Thiamine
(41) Thrombolytic Infusion*
(42) Vassopressin
(43) Vasopressors (Levophed or Dopamine)
(44) Verapamil
(45) Vitamins*

NOTE: EMT-Paramedics may manage and monitor drugs listed here as 21, 23, 32, 35, 40, 44 as part of pre-existing IV therapy only. EMT-P's may not initiate these IV meds.

*M. Demonstrate the technique of aseptic and atraumatic endotracheal and tracheotomy suctioning.

N. Recall the indications for and demonstrate the insertion of an esophageal obturator and esophageal gastric tube airway.

*O. Demonstrate the technique for direct laryngoscopy and insertion of an endotracheal tube and end-tidal CO2 detection in an adult and infant.

*P. Demonstrate the technique for insertion of a nasotracheal tube using the blind technique and by direct laryngoscopy with use of Magill forceps.

Q. Demonstrate the application of electrodes and monitoring of a patient's electrocardiographic activity.

R. Identify on Lead II or modified chest lead - 1 (MCLl) and provide appropriate therapy (according to American Heart Association) for the following cardiac

rhythms:

1. normal sinus rhythm
*2. sinus arrhythmia
*3. sinus arrest
*4. sinus bradycardia
*5. premature atrial contractions
*6. premature junctional contractions
*7. supraventricular tachycardia
*8. atrial fibrillation
*9. atrial flutter
*10. first degree heart block
*11. second degree heart block
*12. third degree heart block
*13. premature ventricular contractions
14. ventricular tachycardia
15. ventricular fibrillation
16. electromechanical dissociation
17. asystole
*18. pacemaker rhythms
19. PVC recognition
20. artifact

S. Demonstrate the proper use of the defibrillator paddle electrodes to obtain a sample Lead II rhythm strip

T. Demonstrate how to properly assess the cause of poor ECG tracing.

U. Demonstrate correct operation of a monitor-defibrillator to perform defibrillation on an adult and infant.

*V. Demonstrate correct operation and indications for an external non-invasive pacemaker (optional).

*W. Apply rotating tourniquets in cases of acute heart failure.

X. Demonstrate proficiency in:

1. biomedical communications, VHF and UHF (RTSS)
2. ECG telemetry
3. medicolegal responsibilities
4. record keeping
5. emergency and defensive driving
6. principles and techniques of light extrication
7. management of mass casualties and triage

Y. In addition to the above skills, the EMT-Paramedic and the EMT-Intermediate should be well versed in pertinent anatomy, pathophysiology, history taking, physical examination, assessment and emergency treatment relating to:

1. the cardiovascular system including recognition of selected dysrhythmias associated with potential acute cardiac compromises;
2. the respiratory system, including pneumothorax, chronic obstructive pulmonary disease, acute asthma, trauma to the chest and airways, respiratory distress syndrome, and acute airway obstruction;
3. chest and abdominal trauma;
4. soft tissue injuries including: burns, avulsions, impaled objects,

eviscerations, amputations, and bleeding control;

5. the central nervous system (medical) in regard to cerebrovascular accidents, seizures, drug overdose, drug incompatibilities, and alterations in levels of consciousness;
6. musculoskeletal trauma including management of fractures, strains, sprains and dislocations;
7. medical emergencies, including: endocrine disorders, anaphylactic reactions, environmental emergencies, poisonings, overdose and acute abdomen;
8. obstetrical and gynecological emergencies including: breech birth, premature birth, abortion, multiple-infant birth, arm or leg presentation, prolonged delivery, prolapsed umbilical cord, pre- and postpartum hemorrhage, ruptured uterus, birth of an apenic infant, preeclampsia or eclampsia, rape, and supine hypotensive syndrome;
9. pediatric emergencies, including: asthma, bronchiolitis, croup, epiglottis, sudden infant death syndrome, seizures, child abuse;
10. behavioral emergencies, including: negotiations, recognition and intervention techniques with suicidal assaultive, destructive, resistant, anxious, bizarre, confused, alcoholic, drug-addicted, toxic, amnesic, paranoid, drugged, raped and assaulted patients.

*Z. Optional skills

Performance of these skills are optional, however, they must be taught in all training programs.

1. Administration of transfusions of blood and its components.
2. Automatic Transport Ventilators (as specified in JAMA, Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiac Care).
3. C-Pap and Bi-Pap Management
4. Chest decompression
5. External cardiac pacing
6. INT Placement
7. Intraosseous infusions
8. MSDH approved Nitroglycerin and Thrombolytic Transport Course
9. Nasogastric Tube Insertion
10. Orogastric Tube Insertion
11. Percutaneous transtracheal catheter ventilation
12. Twelve Lead Electrocardiography
13. Umbilical Vein Cannulation
14. Vascular Access Devices

AA. Optional skills for EMT-Intermediates

1. These optional skills and optional medications must be included in the DEMS approved medical control plan of each ALS provider utilizing them.
   a.) Currently there are no optional skills or optional medications approved by the DEMS.

8.16.1. Other skills and medications not listed in these regulations may not be performed by any ALS provider through ALS trained employees until each skill and/or medication has been approved by DEMS in writing.

8.16.2 ***EMTs of all levels (Basic, Intermediate, Paramedic), may attend and transport by ambulance, patients who have pre-existing procedures or devices that are beyond the EMT's scope of practice if:***

1. there is no need, or reasonably perceived need, for the device or procedure during transport; or

2. an individual (including the patient himself) that has received training and management of the procedure or device accompanies the patient to the destination.

Note: Should doubt exist in regards to the transport of any device or procedure, medical control should be contacted for medical direction.

The EMT-Advanced who functions within the State of Mississippi must be able to demonstrate the following skills and understand the elements of total emergency care to the satisfaction of the local training coordinator and the DEMS. Training programs must be approved by the DEMS and the Department of Education. The skills listed herein will enable the EMT-Advanced to carry out all EMT-Advanced level patient assessment and emergency care procedures.

8.16.3. The EMT's -Advanced's primary responsibility is to the patient and should include both an oral exam and an appropriate physical exam. Scene size-up including: scene safety, mechanism of injury, number of patients, additional help and consideration of cervical stabilization.

8.17. Area and Scope of Practice of the EMT-Advanced Level

8.17.1. ALS personnel are restricted to functioning within the geographic boundaries of their licensed ALS service employer. They primarily provide out-of-hospital emergency care to acutely ill or injured patients while on duty for a licensed ALS provider under medical command authority approved by the DEMS. This does not apply to extended transports which may require EMS personnel to function outside of said boundaries.

8.17.2. EMT-I/Ps may routinely or periodically participate in patient care in the emergency department of a licensed hospital. Their presence may be in the form of:

1. student clinical rotations
2. graduates participating in a clinical rotation for skill retention.
3. field units stationed out of the emergency department under direct physician supervision (i.e., hospital based ALS services)
    a. DEMS Certified EMT-I/Ps will be able to function in the emergency service area of the hospital. They would also be permitted to function in life-threatening emergency situations in other areas of the hospital if directed to do so by the medical command authority.
4. providing assistance to the emergency department staff after delivering a

patient.

*NOTE: In accordance with letter B, EMT-I/Ps must when functioning in the hospital only do so under the direct supervision of a physician.This is necessary because the scope of practice of an EMT-I/P does not coincide with that of any other licensed personnel. ***Paramedics of a hospital owned and based ambulance service may function in the Emergency Department under the direct supervision of a Mississippi licensed physician, physically located in Mississippi, via telemedicine.*** ~~**This would preclude the use of EMT-I/Ps in hospitals,**~~ ***Paramedics may not function in other areas of hospitals*** which do not have on-site 24 hour physician availability. ~~in the emergency service area, except during the time when the physician is physically present is available in the emergency service area.~~

8.17.3. EMT-I/P students may function in all areas of a hospital, under direct supervision of licensed or certified personnel, in a continuing education program or in a training program approved by the licensed ALS service.

8.17.4. An EMT-I/P may perform only those skills authorized by the DEMS regulations relating to their certification.

8.17.5. Because the EMT-I/P's primary responsibility is to respond to emergency situations outside the hospital, they cannot be utilized to replace any members of the hospital emergency service area staff, but may be utilized to support and assist the staff in the care of patients in accordance with their performance standards. Since their scope of practice is limited to a number of specific procedures, which can only be performed under the direction of a physician, all emergency patients clearly require nursing intervention in order to insure that all the patients' needs are met.

8.17.6. It is appropriate to transport patients whose urgent needs or reasonably perceived needs for care exceed the scope of practice for the ambulance attendant, if the following conditions are present:

a.) The patient has existing advanced therapeutics or treatment modalities for a preexisting condition and

b.) The patient is located in a non-hospital setting, and

c.) The patient's condition is considered to be so urgent that the benefits of prompt transport by available personnel to an appropriate hospital outweigh the increased risk to the patient from effecting a delay waiting for qualified medical personnel to arrive.

8.17.7. The person possessing the highest level of certification/license must attend the patient unless otherwise authorized by medical control.

8.17.8. EMTs of all levels (Basic, Intermediate, Paramedic), may attend and transport by ambulance, patients who have pre-existing procedures or devices that are beyond the EMT's scope of practice if:

1. there is no need, or reasonably perceived need, for the device or procedure during transport; or

2. an individual (including the patient himself) that has received training and management of the procedure or device accompanies the patient to the destination.

Note: Should doubt exist in regards to the transport of any device or procedure, medical control should be contacted for medical direction.

Appendix

Appendix 1
Protocols

Protocols are designed by the off-line (system) medical control system to provide a standardized approach to each commonly encountered patient problem. This provides a consistently defined level of pre-hospital care. When treatment is based on such protocols, the on-line physician assists the pre-hospital personnel in their interpretation of the patient's complaint, the findings of their evaluation, and the application of the appropriate treatment protocol. The process should be reviewed periodically in order to consider changing medical standards, new therapies, and data generated from audits of patient care.

In the realm of pre-hospital emergency medicine, there are a limited number of interventions to cover the myriad of problems that may be present. Although advanced life support may be skilled in many maneuvers, there are limitations on what they can accomplish in the pre-hospital setting. Basic life support personnel can do even less. The goal of pre-hospital care is to respond correctly and consistently.

1. Because the types of illnesses and inquiries commonly encountered in a given EMS system may be grouped into broad categories, protocols and standing orders may be established to help accomplish this goal. There are three major advantages to using protocols:

(A) **Pre-hospital personnel may be trained to respond to a given medical problem in a defined manner.** Regardless of the weather, the hostility of the crowd, the immediate danger of any other outside stress, the pre-hospital personnel can consistently treat the problem in a defined manner with minimal chance of omission.

A.1.2. **The EMS system will have a set standard by which care may be audited.** The system and its successes or failures may be measured against consistent standards allowing for necessary change and improvement based on documented evidence, and not on the notion of this year's medical director or any other outside influence not based in fact and logic.

A.1.3. **Protocols provide a standard of medical treatment** for each patient problem so that individual variations necessary for nonroutine patient problems may have a context to aid the on-line physician in a complex treatment regimen.

A.1.4. **Protocol Development**

The development of protocols may include the following steps:

A.1.4.1 List the common illnesses and injuries that are currently encountered by the local EMS system. A chart review on a random basis for all months of the preceding year should suffice. All months are important, for there may be significant seasonal variations with particular illnesses or injuries.

A.1.4.2. This list must also include any life-threatening problems that can be affected positively in the pre-hospital setting, but that are not seen routinely (e.g., anaphylaxis, snake bite).

A.1.4.3. This list may be divided into two general categories-pediatric problems and adult problems-even though there will be duplication within these two lists. Asthma, seizures, trauma, and other illnesses and injuries are common to both groups, but the physical interventions and medications are sufficiently different to justify this separation.

A.1.4.4. Similar problems (e.g., cardiopulmonary, trauma, poisons/overdose, etc.) may be

combined into groups.

A.1.4.5. Some problems that will not fit easily into groupings (e.g., hypothermia) may be listed separately or included in a miscellaneous group called "other."

A.1.4.6. In each of these groups, there will be common parameters, such as the ABCs, vital signs, history of the current illness/injury, medical history, and medications, allergy history.

A.1.4.7. For each of the problems within the group, additional parameters or interventions may be added to further reduce the patient's morbidity or mortality.

A.1.4.8. Additional treatments for special cases may be added to create a more specifically detailed protocol.

A.1.4.9. For a given region, the level of training of the pre-hospital personnel involved, the capabilities of the EMS response system as a whole, the capabilities of the receiving hospital, and the medical opinion in the region must be considered before applying protocols synthesized outside the EMS system.

A.1.5. Protocol Implementation

Protocols are the responsibility of the medical director, who often delegates their development to a committee consisting of emergency physicians and other appropriate physicians. This committee implements the protocols, which reflect the currently optimal method for pre-hospital treatment of the defined problems. All levels of controllers, the medical director and off-line and on-line physicians, must be cognizant of the adopted protocols, and must agree to function "by the book."

Discrepancies of disagreements that evolve should be brought back to the committee for consideration.

Pre-hospital personnel are then trained in the use of the protocols and held accountable through the audit and review process. Variance from protocol must be clearly documented and justified.

Consistently occurring variances, whether or not justified and documented, should induce review of that protocol. Even when no problems emerge, the committee should review all protocols at least annually in light of past experience and new medical insight.

A.1.6. The Mississippi Pre Hospital Protocol and Guideline may be used as a guide and/or template to meet the protocol, procedure and policies for patient care.

Glossary

1. **"Advanced life Support"** - shall mean a sophisticated level of pre-hospital and interhospital emergency care which includes basic life support functions including cardiopulmonary resuscitation (CPR), plus cardiac defibrillation, telemetered electrocardiography, administration of antiarrhythmic agents, intravenous therapy, administration of specific medications, drugs and solutions, use of adjunctive ventilation devices, trauma care and other authorized techniques and procedures.
2. **"Advanced life support personnel"** - shall mean persons other than physicians engaged in the provision of advanced life support, as defined and regulated by rules and regulations promulgated pursuant to Section 41-60-13.
3. **"Advanced Life Support Services"** - shall mean implementation of the 15 components of an EMS system to a level capability which provides noninvasive and invasive emergency patient care designed to optimize the patient's chances of surviving the emergency situation. Services shall include use of sophisticated transportation vehicles, a communications capability (two-way voice and/or biomedical telemetry) and staffing by Emergency Medical Technician-Intermediates or Emergency Medical Technician-Paramedics providing on-site, pre-hospital mobile and hospital intensive care under medical control.
4. **"Ambulance"** - shall mean any privately or publicly owned land or air vehicle that is especially designed, constructed, modified or equipped to be used, maintained and operated upon the streets, highway or airways of this state to assist persons who are sick, injured, wounded or otherwise incapacitated or helpless.
5. **"Ambulance Placement Strategy (System Status Plan)"** - a planned outline or protocol governing the deployment and event-driven redeployment of the ambulance service's resources, both geographically and by time-of-day/day-of-week. Every system has a plan; the plan may be written or not, elaborate or simple, efficient or wasteful, effective or deadly.
6. **"Ambulance Post"** - a designated location for ambulance placement within the system status plan. Depending upon its frequency and type of use, a "post" may be a facility with sleeping quarters or day rooms for crews, or simply a street-corner or parking lot location to which units are sometimes deployed.
7. **"Ambulance Service Area"** - the geographic response area of the licensed ambulance service. The service area must correspond to each individual service license. The service's employee staffing plan, ambulance placement strategy and available resources must be commensurate with the service area.
8. **"Area wide EMS System"** - is an emergency medical service area (trade, catchment, market, patient flow) that provides essentially all of the definitive emergency medical care (95%) for all emergencies, including the most critically ill and injured patients. Only highly specialized and limited-use services may need to be obtained outside of the area. The area must contain adequate population and available medical resources to implement and sustain an EMS operation. At least three major modes exist: (a) multiple urbanized communities and their related suburbs; (b) a metropolitan center and its surrounding rural areas; and (c) a metropolitan center and extreme rural-wilderness settings. The areas may be inter- or intra-state.
9. **"Associate/Receiving Hospital"** - is a designated participating hospital working in

conjunction with and under the supervision of the Resource Hospital to carry out the system implementation. They shall have an emergency department/service which offers emergency care 24 hours a day, with at least one physician available to the emergency care area within approximately 30 minutes through a medical staff call roster. Specialty consultation must be available by request of the attending medical staff member or by transfer to a designated hospital where definitive care can be provided. They must be capable of providing 24-hour-a-day acute care to critically ill patients. They do not, however, have to be equipped with biomedical telemetry within its confines.

10. **"Automated External Defibrillator (AED)"** - means a defibrillator which: a) is capable of cardiac rhythm analysis; b) will charge and deliver a shock after electrically detecting the presence of a cardiac dysrhythmia or is a shock-advisory device in which the defibrillator will analyze the rhythm and display a message advising the operator to press a "shock" control to deliver the shock; c) must be capable of printing a post event summary (at a minimum the post event summary should include times, joules delivered, ECG) and d) an on screen display of the ECG. (optional)
11. **"Base Station Hospital"** - is designated participating hospital working in conjunction with and under the supervision of the Resource Hospital to carry out the systems implementation. These hospitals may function as a pre-hospital Communications Resource as defined in the section on Medical Direction. The hospitals may participate in training and evaluation of ALS personnel. They must have emergency departments staffed 24-hours-a-day by critical care nurses and at least one emergency physician or physicians under the direction and supervision of a physician totally versed and committed to emergency medicine.It must have specialty consultation available within approximately 30 minutes by members of the medical staff or by senior-level residents. Pre-hospital ALS personnel transmit patient information to the Base Station Hospitals and receive appropriate medical directions from them. The hospitals should be equipped with voice and biomedical telemetry equipment. Each Base Station Hospital must have an On-Line Medical Director.
12. **"Basic Life Support Services (BLS)"** - Implementation of the 15 components of and EMS system to a level of capability which provides pre-hospital noninvasive emergency patient care designed to optimize the patient's chance of surviving the emergency situation. There would be universal access to and dispatch of national standard ambulances, with appropriate medical and communication equipment operated by Emergency Medical Technicians-Ambulance. Regional triage protocols should be used to direct patients to appropriately categorized hospitals.
13. **"Board"** - shall mean the Mississippi State Department of Health.
14. **"Certificate"** - shall mean official acknowledgment that an individual has successfully completed the recommended basic emergency medical technician training course referred to in this chapter which entitles that individual to perform the functions and duties of an emergency medical technician.
15. **"Critical Care Units (Centers)"** - are sophisticated treatment facilities in large medical centers and hospitals that provide advanced definitive care for the most critically ill patients. The units are available for the diagnosis and care of specific patient problems including major trauma, burn, spinal cord injury, poisoning, acute cardiac, high risk infant and behavioral emergencies.
16. **"Communication Resource"** - an entity responsible for implementation of direct medical control (See detailed description in section on Medical Direction).

17. **"Delegated Practice"** - Only physicians are licensed to practice medicine. Pre-hospital providers must act only under the medical direction of a physician.
18. **"Direct Medical Control"** - When a physician provides immediate medical direction to pre-hospital providers in remote locations.
19. **"DOT"** - shall mean United States Department of Transportation.
20. **"Emergency Medical Condition"** - a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in
    a. placing the patient's health in serious jeopardy,
    b. serious impairment to bodily functions, or
    c. serious dysfunction of any bodily organ or part.
21. **"Emergency Medical Services (EMS)"** - Services utilized in responding to a perceived individual's need for immediate medical care to prevent death or aggravation of physiological or psychological illness or injury.
22. **"EMS Personnel"** - Key individual EMS providers. This includes physician, emergency and critical care nurse, EMT-Basic, EMT-Intermediate, EMT-Paramedic, dispatchers, telephone screeners, first aid responders, project administrators and medical consultants and system coordinators.
23. **"EMS System"** - A system which provides for the arrangement of personnel, facilities, and equipment of the effective and coordinated delivery of health care services in an appropriate geographical area under emergency conditions (occurring as a result of the patient's condition or because of natural disasters or similar conditions). The system is managed by a public or nonprofit private entity. The components of an EMS System include:
    a. manpower
    b. training
    c. communications
    d. transportation
    e. facilities
    f. critical care units
    g. public safety agencies
    h. consumer participation
    i. access to care
    j. patient transfer
    k. coordinated patient recordkeeping
    l. public information and education
    m. review and evaluation
    n. disaster plan
    o. mutual aid
24. **"Emergency medical technician"** - shall mean an individual who possesses a valid emergency medical technician's certificate issued pursuant to the provisions of this chapter.
25. **"Emergency medical technician-intermediate"** - shall mean a person specially trained in advanced life support modules as authorized by the Mississippi State Department of Health.
26. **"Emergency medical technician-paramedic"** - shall mean a person specially trained in an advanced life support training program authorized by the Mississippi State Department

of Health.

27. **"Executive officer"** - shall mean the executive officer of the State Department of Health or his designated representative.
28. **"Implied Consent"** - shall mean legal position that assumes an unconscious patient, or one so badly injured or ill that he cannot respond, would consent to receiving emergency care. Implied consent applies to children when parent or guardian are not at the scene.
29. **"Intervener Physicians"** - A licensed M.D. or D.O., having not previously established a doctor/patient relationship with the emergency patient and willing to accept responsibility for a medical emergency scene, and can provide proof of a current Medical Licensure.
30. **"Lead Agency"** - is an organization which has been delegated the responsibility for coordinating all component and care aspects for an EMS system.
31. **"Licensure"** - shall mean an authorization to any person, firm, cooperation, or governmental division or agency to provide ambulance services in the State of Mississippi.
32. **"License Location"** - shall be defined as a fixed location where the ambulance service conducts business or controls the deployment of ambulances to the service area.
33. **"Medical Control"** - shall mean directions and advice provided from a centrally designated medical facility staffed by appropriate personnel, operating under medical supervision, supplying professional support through radio or telephonic communication for on-site and in-transit basic and advanced life support services given by field and satellite facility personnel.
34. **"Medical Direction"** - (medical accountability) - When a physician is identified to develop, implement and evaluate all medical aspects of an EMS system.
35. **"Medical Director"** - (off line, administrative) should be a physician both credible and knowledgeable in EMS systems planning, implementation, and operations. This off-line physician assumes total responsibility for the system's activities. He is appointed by the local EMS lead agency. The administrative medical director works in close liaison with government agencies, public safety and disaster operations, legislative and executive offices, professional societies, and the public. Off-line program activities include liaison with other state and regional EMS medical directors to conceptualize clinical and component system designs, establish standards, monitor and evaluate the integration of component and system activities.

    This off-line physician assures medical soundness and appropriateness of all aspects of the program and is responsible for the conceptual and systems design and overall supervision of the EMS program.

    The administrative (off-line) medical director in conjunction with the supervisory ALS (on-line) medical directors of each Base Station Hospital, medical directors for paramedic services, medical directory for EMS training, and critical care consultants develop all area protocols. These protocols serve as the basis for EMS system role definition of ALS personnel, curriculum development, competency determination, and maintenance, monitoring, and evaluation.

    The off-line medical director meets on a regular basis with on-line medical directors and the EMS training director to evaluate on-line system performance, to review problems, and suggest changes in treatment, triage, or operational protocols. All on-line medical directors must be approved by the off-line medical director.
36. **"On-Line (Supervising ALS) Medical Director"** - On-Line medical control is provided through designated Primary Resource and Base Station Hospitals under the area direction

of a supervisory ALS medical director who is on-line to the pre-hospital system stationed at the designated Base Station Hospital. Each provider of ALS must also have an on-line medical director. The system must also have an on-line medical director for EMS training. These supervisory medical directors are organizationally responsible to the administrative (off-line medical director of the local EMS lead agency for program implementation and operations within his area of jurisdiction).

The ALS (on-line) medical director supervises the advanced life support, pre- and inter-hospital system and is responsible for the actual day-to-day operation of the EMS system. He carries out the "EMS systems design" in terms of pre-and inter-hospital transportation care and provides ALS direction to EMS providers depending on the transportation care and provides ALS direction to EMS providers depending on the system's configuration. He monitors all pre-hospital ALS activities within that system's region or area of responsibility. The ALS physician must review and monitor compliance to protocols for both the pre-and inter-hospital settings.

The ALS (on-line) medical director in conjunction with the EMS training medical director reviews paramedics, intermediates, mobile intensive care nurses, and physician competencies and recommends certification, re-certification, and decertification of these personnel to the EMS health officer of the lead agency responsible for the certification decertification, and recertification of EMS personnel. Monitoring the competency of all pre-hospital EMS personnel activities is within his responsibility.

He attends medical control meetings where area system performance and problems are discussed and recommendations to the administrative off-line director are made. He also conducts regular case reviews and other competency evaluation and maintenance procedures and reports back to the administrative (off-line) medical director.

This ALS (on-line) physician assumes the supervision and responsibility for all advanced care rendered in an emergency at the scene of an accident and en route to the hospital under his area jurisdiction. Each on-line medical director representing the hospitals providing medical control has the authority to delegate his duties to other emergency department physicians who may be on duty and placed in a position of giving medical direction to pre-hospital ALS personnel.

37. **"Permit"** - shall mean an authorization issued for an ambulance vehicle as meeting the standards adopted pursuant to this chapter.
38. **"Pre-hospital Provider"** - all personnel providing emergency medical care in a location remote from facilities capable of providing definitive medical care.
39. **"Primary Resource Hospital"** - The Primary Resource Hospital (PRH) is responsible for implementing the medical control design of the ALS system. It has the major functional responsibility for implementing protocols (treatment, triage, and operations) and the monitoring of program compliance to these by on-line medical supervision.

    This hospital must be an acute general care facility equipped with voice and biomedical telemetry equipment. It should be staffed with critical care nurses and emergency physicians, or physicians under the direction and supervision of physicians totally versed and committed to emergency medicine. It must be capable of functioning as a Communications Resource as described in the section on Medical Direction and pre-hospital ALS personnel should be able to receive medical control and direction from this facility anywhere within the district. It is also understood that this facility is responsible for overall supervision of medical directions that may be issued by other participating hospitals within the district.

This hospital provides and coordinates interdisciplinary training for ALS providers within the district. The lead agency may choose to delegate or contract this responsibility to other institutions."

40. **“Standing Orders”** - are those specific portions of the treatment protocols that may be carried out by ALS personnel without having to establish contact with medical control facility. These standing orders represent nationally recognized treatment modalities and allow the ALS personnel to treat life-threatening problems without delay.
41. **"Transfer"** - The movement (including the discharge) of a patient outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly with) the hospital, but does not include such a movement of a patient who (a) has been declared dead, or (b) leaves the facility without the permission of any such person.
42. **"Treatment Protocols"** - are written uniform treatment and care plans for emergency and critical patients. These treatment plans must be approved and signed by the off-line medical director and/or medical groups. (Appendix 2)
43. **"Triage Protocols"** - are region wide plans for identifying, selecting and transporting specific critical patients to appropriate, designated treatment facilities.